Hastings and Bexhill Mencap Society

Westwood

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

We inspected Westwood on the 16 January 2017 and the inspection was unannounced. Westwood provides accommodation and support for up to nine people with a learning disability who require accommodation and personal care. The service was in a house and people had bedrooms on the ground and first floor which were accessed via a staircase. Care and support was provided to people living with a learning disability, dementia and mental health needs..

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safe. Staff understood the importance of people's safety and knew how to report any concerns they might have. Risks to people's health, safety and wellbeing had been assessed and plans were in place, which instructed staff how to minimise any identified risks to keep people safe from harm or injury.

There were suitable arrangements in place for the safe storage, receipt and management of people's medicines. Medicine profiles were in place which provided an overview of the individual's prescribed medicine, the reason for administration, dosage and any side effects.

There were sufficient numbers of staff employed to meet people's needs and staff knew people well and had built up good relationships with people. The registered provider had effective recruitment procedures in place.

The registered manager and staff had received training to meet people's needs and were knowledgeable about of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had not been completed for every decision taken for people who may not be able to consent.

Staff treated people as individuals with dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. Staff were skilled to approach people in different ways to suit the person and communicate in a calm and friendly manner which people responded to positively.

Peoples' health was monitored and referrals were made to health services in an appropriate and timely manner. Any recommendations made by health care professionals were acted upon and incorporated into peoples' care plans.

People who wanted to be occupied had busy lifestyles which reflected their lifestyle choices and likes and dislikes. People's privacy and dignity were respected and upheld by staff who valued peoples' unique characters.

Staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout our inspection, such as staff sitting and talking with people as equals. People could have visitors from family and friends whenever they wanted.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People led full and varied lives and were supported with a variety of activities often with one to one support.

Complaints were used as a means of improving the service and people felt confident that they could make a complaint that any concerns would be taken seriously.

There was an open, transparent culture and good communication within the staff team. Staff spoke highly of the registered manager and their leadership style. The management team had positive relationships with the care staff.

The registered manager took an active role within the service and led by example. There were clear lines of accountability and staff were clear about their roles and responsibilities. The provider had robust systems in place to assess and audit the quality of the service. However the quality checks that we could see were happening were not always written down in one document.

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.

People were protected from the risk of avoidable harm and abuse by staff who understood their responsibilities under safeguarding.

Risk assessments were comprehensive and reduced hazards.

Staffing numbers met people's needs safely.

Medicines were managed safely and stored and administered within best practice guidelines.

Is the service effective?

Good

The service was effective.

Staff received sufficient and told us that they felt supported by the registered manager.

Consent was being sought and the principles of the MCA complied with in most cases.

People received adequate food and drink and people with special diets had their food and fluids safely.

People's healthcare needs were met and people had access to a wide range of healthcare professionals when they needed them.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information about people to effectively support them and build up caring relationships.

People and their families were involved in their lives and could make decisions about their care.

People were treated with dignity and respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs.

Complaints were responded to appropriately and were used as a tool for improving services.

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive.

The management team provided clear leadership to the staff team and were a visible presence in the service.

Quality monitoring systems had been effective and had led to changes when needed.

Westwood

Detailed findings

Background to this inspection

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

This inspection took place on 16 January 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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. Prior to our inspection we spoke to the local authority's quality monitoring team. Where people have communication problems we sometimes use the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In this inspection we did not use a SOFI due to the small size of the service.

As some people who lived at Westwood were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, the chief executive, five care staff, seven people and two people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at three people's care plans, medication administration records, risk assessments, accident and incident records, maintenance records, complaints records two staff files and quality audits that had been completed. We last inspected Westwood in October 2015 when we found they were rated requires improvement. At this inspection we found that improvements had been made.

Good

Is the service safe?

Our findings

People with were protected against the risks of potential abuse. Staff were knowledgeable about adult safeguarding and their roles in protecting people. One person told us, "I am safe here because the staff make sure I'm safe and they help us all." One staff member told us, "Safeguarding is about looking out for people we support and looking out for the signs of abuse. We report any situations that occur on an incident form that goes to the manager and on to the community learning disabilities team." One relative told us, "Yes X is 100% safe. We've been there quite a few times and she's so happy there and they've literally changed her life around. Whenever we arrive there's always someone to answer the door with her, so she's 100% safe."

At our last inspection on 27 October 2015 we found that the whistleblowing policy needed to be reviewed to ensure that staff used this for legitimate purposes. At this inspection we found improvements had been made. The whistleblowing policy had been reviewed and effectively explained the procedure for staff members to follow. People had access to information about safeguarding and how to stay safe. The culture in the service ensured people were thinking about safeguarding. There were signs around the service in appropriate locations prompting staff and visitors to be mindful of safeguarding and the information was in an easy read format for people. The registered manager had made three referrals to the local authority safeguarding adult's team, one of which was investigated as a safeguarding. The referrals had been made appropriately and the registered provider had been open in their communications with the local authority. All staff members were trained in safeguarding and talked confidently about the different types of abuse and the correct reporting procedures, including whom to contact should concerns need to be reported externally.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. A range of risk assessments were in place, which covered areas of care, including nutrition and hydration, medication and pain, and food allergies. Each risk assessment considered the potential hazard and the control measures required to minimise the level of risk. . Environmental risks were being managed effectively through regular monitoring and checks conducted by the registered manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The registered manager ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the hazard and what actions were required of staff to reduce the risk. Fire safety was managed effectively with regular servicing of equipment and weekly alarm tests and regular fire drills which reported on the outcome of each drill. A positive attitude to managing risks was encouraged by the registered manager. One person had displayed some behaviour's that challenge following a change in their life. The registered manager implemented a behaviour management strategy that included an overview of the person's behaviours, an explanation of the triggers, which interventions staff members could use the level of risk for the person and an action plan to keep the person and staff members safe. This had led to a reduction in incidents and enabled the person to manage their anxieties.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. One relative told us, "There's always plenty of staff when we visit and we've never seen people waiting for help and not getting it." A staff member told us, "We're always well covered and if we need it [registered manager] will get agency staff and we use regular agency who our residents know. On the whole we have a good staff team and we pull together if anyone is off sick. We don't feel rushed and work well together. We have lots of time to speak to people; we have time to spend one to one and we have extra staff at weekend to give people one to one support." On the day of our inspection one member of staff had called in sick and we did not witness care or support being rushed or people not having their needs met. Two people were supported to go out and do their banking and some personal shopping despite the morning rota having one fewer member of staff than planned. The registered manager typically scheduled three staff members in the morning and two staff members in the afternoon, one of whom stayed to do a sleep in shift overnight. On occasions when people's needs increased the registered manager had scheduled an additional waking night member of staff to keep people safe. The registered manager also increased staffing numbers to support people to attend social functions. Recent social activities, where additional staffing was used, included a disco and a pantomime.

Safe recruitment procedures were being followed by the registered provider. We looked at the recruitment records for two people, one of whom had been recruited in the 12 months before our inspection. In both cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited staff member to maintain the safety of the recruitment process. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom before starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible. There were detailed and scored records of interviews, using role-specific question formats. Regular supervision and appraisals between staff members and the registered manager were happening and people had the opportunity to raise concerns in structured meetings.

At our last inspection on 27 October 2015 we found that competency checks were not taking place after medicines errors had occurred. At this inspection we found that improvements had been made. There were safe medicines administration systems in place and people received their medicines when required. People kept their medicines in their own room and were supported to take as much responsibility of their own medicines as was safe. The service used a monitored dosage system where tablets arrive from the pharmacy pre-packed and in a separate compartment for each dosage time of the day. We checked the medicines administrations charts for people and found that medicines were being signed in to the service and counted correctly, meaning that it was easy for the registered manager to conduct audits of medicines. Where the registered manager had identified issues with medicines they had acted openly and in people's best interest. One member of staff had discovered a tablet missing from one person's afternoon dosage and suspected that they had administered it by mistake in the morning. This was reported the person's GP, and advice was sought from the NHS 111 non-emergency telephone helpline and recorded on an incident form. The staff member was stopped from supporting people to take their medicines and was retrained. The registered manager checked the member of staff's competency with medicines before they were allowed to support people with their medicines again. This ensured that the risks around potential medicines errors were minimised.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "Staff really care: If you've got any problems you can go to them and they sort it out. If you're not well they help you." Another person commented, "Staff help me. I can't use the washing machine but they show me how to so I can do it." One relative told us, "X is non-verbal and they communicate as best as they can with X but she can communicate well with her actions and facial expressions; I know the staff can communicate well with her because she's happier there than she's ever been."

People were supported by staff who had access to a range of training to develop their skills and knowledge they needed to meet people's needs. One staff member told us, "I think our training is quite good and we have packs we can take away and complete, we get paid extra hours to complete these. We have group training at the office at times. We had a few issues with one person with behaviours and we all voiced some worries and the manager arranged some special training around challenging behaviour." The registered manager had ensured that all staff had received a comprehensive training programme and that training was kept up to date with regular updated courses. Staff could access standard training such as fire safety, first aid and health and safety and in addition to this there were also specialised courses such as dementia available. New staff were supported to complete an induction programme before working on their own. They told us, "It was a long and thorough induction: I had to shadow shifts, read care plans, and was introduced to the guys who live here and I observed care."

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 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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe. Records showed that the registered manager had made appropriate referrals for DoLS and were using the principles of the MCA to protect people. We reviewed care plans and saw that each people's care plan had a section on mental capacity. One person's care plan highlighted that the person had fluctuating capacity due to a medical condition and advised staff members that if any decisions were to be made during these times a best interests meeting would need to be arranged. Other people had signed consent forms to allow their photographs to be used in their care plans. However, we found one instance where a decision around personal care had been made on someone's behalf without a capacity assessment or best interest meeting. We raised this with the registered manager who took immediate action to rectify the situation.

We recommend that the registered manager reviews all care plans to ensure all decisions made on behalf of people comply with the principles of the Mental Capacity Act 2005.

People appeared to enjoy mealtimes and were involved in preparing the meals that they liked. One person told us, "I like cooking and cook my own dinners." One relative told us, "I've been present at mealtime and when they're preparing the meals. The food is absolutely top notch, brilliant, well prepared, well thought out. We say we'd like to have dinner at Westwood as it's so good and they cater for special diets as some of the guys are dairy free and they do it well. Last Sunday they dished up roast lamb and it looked and smelled amazing." On the day of our inspection one person was helping to prepare the main evening meal and spoke about how they enjoyed being involved in cooking and not having meals made for them. Another person had assisted in preparing the vegetables and showed us the recipe book that the service has compiled of healthy but tasty meals. The person showed us their favourite recipes and spoke about how they make each one. One staff member told us, "All the food is made fresh from scratch including all sauces; we never use pre-made or processed food. I take the recipes home and cook them there and my kids prefer it." There was a winter and a summer menu in use and we saw the winter menu contained wholesome traditional food that people clearly enjoyed, such as beef stew and dumplings and sausage casserole. People were encouraged to drink at regular intervals and staff members encouraged people to make their own drinks. The registered provider used food charts to show what people ate and these had been completed consistently.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. One person told us, "I had a stomach bug last year and got to see the doctor and he helped me. I got some tablets." Another person told us, "We get treatment if we're ill and we have staff with us to help. I've got an appointment this week." Care plans contained medical histories and these were full and detailed. One person's had been updated to mention a recent diagnosis. There was a section in each care plan for 'overall health' which gave information on the person's previous medical history and current health concerns, as well as detailed information such as around epilepsy and tissue viability. The service was using nationally accepted frameworks to monitor people's health such as the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. People who were at risk of being under or overweight were assessed accordingly and staff members monitored people's weight. One relative described to us how their loved one had been supported to lose a significant amount of weight since being supported by the service. One person who experienced mental health issues had been referred to the community mental health team and their care plan clearly explained the type of support they would need during times that they experienced mental ill health.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "I love it here. I'm really happy here: they really care and it's the best place I've ever been." Another person told us, "I want to stay here for good. If you've got any problems you can go to [manager] or any of the staff." One relative told us, "They are always very attentive and very happy. X gets on with all the staff and they're always pleased to see her. I cannot fault the staff. They've bought [an electronic tablet] so she can speak to us when she wants to."

People had developed meaningful caring relationships with staff and this was evidenced by how people communicated with staff. One relative told us, "It's their general interaction with all the service users there, the way they talk to them and include them: they [staff] have a sense of humour and so do the residents and that's put to use. There's a couple of ladies that have jobs around the house to do light cleaning and they said 'I worked blooming hard today, I've done this and that' and [manager] was saying 'you've missed a bit here' and it was all said laughing and joking and I can tell they enjoy a joke. When they prepare food they loved being joshed by staff saying 'hurry up you're not working hard enough' and they like this joke: I see it happening a lot." On the day of our inspection we observed very open, familiar relationships between people and their staff and these were apparent throughout the inspection. We observed staff chatting to people in their rooms as they passed and conversations happened naturally in all areas of the service, instigated by people and staff members.

People's independence was encouraged and their involvement in the day to day running of their service was apparent. On the day of our inspection a weekly food shop was delivered and people were encouraged to bring the bags in to the kitchen and to put the food away. Staff members did not do things for people but instead supported people to do as much for themselves as possible. Staff knew peoples preferences and spoke about whom had ordered what items such as, "X has got her [branded cereal]; she loves them doesn't she." We observed one person doing the washing up. Staff members ensured that all other dishes and utensils were put away before the person started the task. When we enquired as to the reason for this we were shown that the person struggled to clean all the items to a hygienic standard so staff re-did the task after the person had finished. One staff member explained that the person would never learn how to wash up if they did not practice, but that all staff were aware of ensuring the dishes were clean for others to use. We saw that staff members were sensitive to the person's feelings and ensured they did not witness the task being re-done. The laundry room had two washing machines both of which had laminated sheets with pictures and simple wording to show people how to programme the machines. The registered manager explained that this was done as previously people couldn't do their own washing and were reliant on staff doing it for them. The explanation sheets had helped people to manage their own laundry with some support. We observed that whenever the doorbell rang people were supported to answer their own front door.

People's privacy and dignity was respected by staff. One persons' care plan showed how the person had been startled by staff entering their room as they were not able to hear staff members knocking on their door. The registered provider had appropriately assessed and provided a sensor that was placed under the

persons pillow to alert them that someone was about to enter their room. We observed that staff members routinely knocked on people's doors before entering and that people were confident to tell staff members they didn't want to see them, and staff respected this. One staff member told us, "We have guidelines to follow during personal care to protect peoples' dignity, so we make sure we follow them. We ask people what they want and follow what they say and always explain what we are doing." One relative commented, "A couple of people with mental health issues struggle at times and there's a lot of care taken to protect those people and others, as they may act inappropriately in communal areas of the home. They balance meeting the needs of those ladies as well as protecting the other guys."

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. One staff member told us, "We always let people make a decision and 90% of the time, people have already made up their minds and if it was a really unhealthy choice or very expensive, we always talk about the consequences. With every decision we talk about the outcome of their choices and they generally all come around to making a good decision and if they don't they know there is a consequence." One person's care plan stated, "I have control of what I do each day and I often voice my preferences and staff will listen and help me." There were regular house meetings where people were invited to discuss recent events and make suggestions for new activities. One meeting detailed how people had asked for more information about the Chinese New Year so they could celebrate it. Menus were discussed and new dishes were talked about. One person wanted to have cups with peoples pictures printed on them and they were advised about how to do this. Cleaning of the service was also discussed at meetings and people could talk about which tasks were not getting done and any changes to the cleaning rota.

People were supported to express their own cultural heritage and explore other cultures. The registered manager had begun to arrange some events which explored different cultures and the way people lived in other parts of the world, the foods eaten, clothing, traditions and celebrations. The registered manager told us, "We thought we would start by asking [person] and [person] if they would like to have a day or plan an event where they could talk about the differences between the way people live in their birth country (both people were born abroad) compared to their lives here. [Person] and [person] were very happy to plan an afternoon/evening where they decorated the dining room with their national flags, pictures of typical dress including clogs! Pictures of typical things they associated with their country of birth." Staff members helped to support the people to research their national foods and then they went shopping for ingredients and prepared and cooked with support to then hold their own nation's night. The registered manager told us, "They gave a little talk explaining differences in lifestyle and photos were taken. It was a very positive evening and the next planned event is to research information about China and celebrating the Chinese New Year at the end of January, we are going to try using chop sticks!"

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One person told us, "I have a brother who lives nearby and can visit him. I can choose what to have in my bedroom and can choose my own furniture." One relative told us, "They observe X, listen to her and listen to me and they react and adapt when things go wrong and want to know why it happened, how we can stop it happening again and looked at situation. They implemented some training specifically for my daughter." One staff member told us, "Some people prefer to get dressed in the bathroom and we take their clothes to the bathroom, other people like to put their own bubbles in the bath; other people prefer a shower and we always give every option we can and that's a massive thing we hammer home to new staff in the induction."

Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them. Each care plans contained a life story section to explain key details of people's lives that each person wanted to share with staff. One person's life story contained information about the country they grew up in and had lots of details about the person's family history. Important markers in the person's life were explained such as dates of significant people's passing and how the person likes to mark this date each year. Care plans were written in the first person and used people's own language. One plan stated, 'I love my TV and love my home. I like to go out with staff to have one to one time and I also enjoy swimming in the nice weather and cooking. I don't like to walk too much these days because I get wobbly.' Care plans contained goals for each person and it was recorded when these had happened. One person had wanted to go to the local library and to buy their own curtains for their room and both of these goals had been achieved.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests and staff provided support as required. One person explained to us that they were changing day centres and were looking at alternative services. Staff members had supported the person to visit three other services and involved the person's social worker so they were aware of which options were being considered. The person told us, "I like doing art; on Fridays I do active art which is performance. Every year we do a show. This year we're doing Queen and I'm doing a solo with my own mic." People spoke to us about their hobbies and how they got to pursue these. One person told us, "I like photography I take photos of new staff to go on the board [to show people which staff is working that day]." Care plans contained a section for activities which detailed people's current interests e.g. pampering, cinema and arts and crafts; what type of support they would need, e.g. staff to arrange transport; what support is needed in the community, e.g. road safety; outcomes for the person, e.g. to learn new skills and increase independence. We saw one person's activities planner which contained exercises, banking and shopping, laundry and cleaning as well as social activities. One person told us, "I've been busy over the weekend. We went out for dinner and to the pantomime and when we got back we had a lovely roast dinner and cake."

People's individual communication needs were met by staff who understood them. Care plans explored people's communication needs and gave staff the guidance they would need to communicate effectively

with people. For example, one care plan stated, 'X may lose track during a conversation or have minor difficulty finding the words they need. When this occurs a gentle reminder of their last statement or suggesting the word they may have missed might help.' Staff were advised to be sensitive to the conversations and the person's feelings regarding such assistance. The care plan advised staff members to keep language simple and to keep questions and commentary straightforward to enable the person to take an active role in any conversation. The plan went on to highlight potential problem areas such as complex sentences, multiple choice questions, and convoluted topics, and described how these may erode the person's confidence. This would enable staff members to support the person to be an active part of their peer group or any activities they were participating in.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service recorded all complaints in a complaints log and these had been followed up in line with the registered provider's complaints policy. We reviewed a sample of complaints and found that the registered manager had ensured that learning was put in place from any shortfalls in service and issues were resolved. For example, one person's relative had complained about the procedure for collecting their loved one from the service. The registered manager had investigated the matter and implemented a solution that allowed the person to see their relative without experiencing heightened anxiety. There was a complaints and 'niggles' sign on the noticeboard that reminded people to speak to a support worker if there was something they were not happy about. Peoples care plans contained acknowledgment of any assistance they would require to make a formal complaint. One person's care plan stated, "X requires an advocate to raise any complaints with the organisation as they are unable to understand or access the organisations complaints procedure them self. X's advocate should be given a copy of the complaints procedure." We saw evidence that the person had raised some issues at a residents meeting and that they were dealt with quickly and the person was reminded that they could take the matter further if they were not happy with the outcome.

Good

Is the service well-led?

Our findings

The registered manager provided effective leadership to the service and people spoke in positive terms about the management of the service. One person told us, "[Manager] is very busy but we can always talk to her." Another person commented, "Other places didn't let us open our letters but any letters or appointments here we get them; if it's private we keep it. [Manager] changed it all and she's the best manager we've ever had." One relative commented, "[Manager] is just amazing. She is organised, caring, and empathetic; she loves them all and knows everybody's little foibles she knows when to step in and when to step back and works long hours above and beyond what she's paid for. I know the problems with getting staff but [Manager] has worked so hard to get a good team of staff so her leadership is really good and her example is amazing and she's really good at her job. The residents never have second best because they have a learning disability: they get the best." Another relative told us, "[Manager] often phones me up and gives me a run down on how things are and we have a long catch up on the phone."

At our last inspection on 27 October 2015 we found that quality monitoring audits did not contain goals for care plans or service improvement plans. At this inspection we found that improvements had been made. People's care plans now included goals for staff to support people to meet. We noted that some goals had been met and re-set and that some other goals had not been met. Where goals had not been met we raised this with the registered manager and were informed that plans had been made but in some cases people had decided not to pursue these specific goals at the arranged time. We saw that a service improvement plan had been written by the registered manager and that this was organised in to sections for 'what is planned', 'how we are going to do it', 'who is responsible'; 'date for completion' and 'date for review'. This meant that any proposed improvements were tracked through to completion with named people who held responsibility for each task.

In addition to the business plan there were additional quality audits conducted by the organisations chief executive and treasurer who conducted a 'Trustees and CEO audit'. For example when there was an issue with medicines errors, the chief executive and the treasurer made several visits to conduct audits and ensure staff members were competent. We viewed audits and saw that senior managers had an effective oversight of the service. The registered provider used a computer software programme to organise all electronic files. We asked the registered manager to explain how this created effective audits and were shown how the programme automatically alerts the registered manager when care plans or risk assessments were in need of an update or review. People's appointments, such as dementia clinics, are also entered in to the system so that important appointments always had reminders. The registered manager explained that one person with a sensor under their pillow needed the batteries changed every three months and there had been an automatic alert set so that this was never missed. The system created a status page every day which generated all essential information and this was then entered on to the shift planner for staff members to follow.

Although we could see that all quality monitoring checks, such as health and safety checks and water temperature checks were happening there was no one form that recorded these checks or evidenced that they had happened. This meant that if the registered manager was to be absent from the service the

necessary checks could be at risk of being missed. The registered manager told us, "Because I am based in the building I know if something has been missed." However, the registered manager acknowledged that it would be beneficial to have all checks recorded on one document.

We recommend that the registered manager reviews the recording of periodical checks to ensure that quality audits can be evidenced clearly.

The service promoted a positive culture that was person-centred, open, inclusive and empowering. Professionals and relatives were encouraged to visit at any time. One relative told us, "It's just like a home and this is just what the people need, a home: it's a welcoming home. People were institutionalised for many years and we don't know what they went through there and where X is now is a home and a welcoming place to be." Another relative told us, "It's lovely and feels like a home. I like the way they encourage everybody to do as much as the can and I know my daughter does a lot more things than at home like make her packed lunch. The home supported not only X but us as well when she moved and that comes from the top and the culture there is good and we see the staff getting on well together and I've never seen anyone speak anyway other than positively and nicely to the residents." The registered manager told us, "My vision for people here, particularly the younger people, is that we enable them to do more for themselves and possibly be able to move on to their own flat with support. I would like to see the whole service move on so staff stand back and support rather than do things for people."

People and their relatives were empowered to contribute to improve the service. The service conducted an annual quality survey to seek feedback and ideas from people. In the annual survey eight out of nine people had completed the surveys and half of respondents stated they did not understand why they had to have a care plan. The service had begun the process of designing new care plans so that people could engage with their care plan more effectively and understand why the information in the plan was needed. The registered manager explained that they will tailor new care plans to people's communication needs so that if a person is non-verbal they will have a pictorial care plan to enable them to understand what the document is about and why it is needed. Relatives had completed surveys and had been positive about the service. One relative had noted that a person was not using a form of sign language to aid their communication as much and the management team had noted that this requires further encouragement from all staff. Professionals involved in the service had completed a survey and were positive in their feedback.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.