East Riding of Yorkshire Council

New 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

This inspection took place on 7 March 2016 and was unannounced. We previously visited the service on 8 January 2014 and found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to eight adults with a learning disability or autistic spectrum disorder, and on the day of the inspection there were eight people living at the home. The home is located in Beverley, in the East Riding of Yorkshire. It is close to town centre amenities and on good transport routes.

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

Permanent staff confirmed that they received induction training when they were new in post and that they shadowed experienced staff before they worked unsupervised. This was confirmed in the records we saw on the day of the inspection. Staff told us they were happy with the training provided for them and the training record evidenced that most staff had completed training that was considered to be essential by the home.

People told us that they felt safe living at New House and we found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. We also saw care staff assisting people to mobilise on the day of the inspection and noted that mobility equipment was used correctly and safely.

We saw that people were encouraged to make their own decisions and when they needed support to make decisions, these had been made in their best interests.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed. We saw that there were sufficient numbers of staff on duty to meet people's individual needs, and to allow people to undertake their chosen activities.

Only senior staff at the home had responsibility for the administration of medication and there was evidence they had completed appropriate training. We saw that medication was administered, stored, recorded and disposed of safely.

People's nutritional needs had been assessed and were recorded in their care plans, along with their likes and dislikes in respect of food and drink. People's specific needs in respect of eating and drinking had been

met.

The premises were being maintained in a safe condition and people told us they were able to find their way around the premises with no difficulty.

There were effective quality assurance systems in place that monitored the safety of the premises, that staff were following the home's policies and procedures and that people were receiving the care they needed to meet their assessed needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

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

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

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

People's nutritional needs were assessed and people told us they liked the meals at the home.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by

staff, and people were encouraged to be as independent as possible, with support from staff.

People told us that their privacy and dignity was respected by staff and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

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

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager or one of the care staff if they had any concerns.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

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

New 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.

The inspection took place on 7 March 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authorities who commissioned a service from the registered provider and information from health and social care professionals. The registered provider was asked to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with one person who lived at the home in depth, and chatted to others. We also spoke with three members of staff and the registered manager. We were unable to speak with some people at the home due to their limited verbal communication; we spent time observing their care and their interaction with other people who lived at the home and staff to determine that their needs were being met.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, including training, quality assurance and health and safety.

Good

Is the service safe?

Our findings

People's care plans included a section called 'This is what I need to keep me safe and well'. People told us that they felt safe living at New House. One person told us, "Staff check me during the night – I feel safe." We asked staff how they kept people safe and they told us that their training on topics such as moving and handling helped them to provide safe care. They said that the premises were secure and they were aware of any risks, such as people who had seizures and people's swallowing problems. One member of staff told us, "We take advice from SALT [Speech and Language Therapists] and are very careful to follow that advice. Staff are experienced and know each individual well." A casual member of staff told us they "Learned a lot" from more experienced staff when they were new in post.

We saw the home's safeguarding policy and procedure and noted that it included updated guidance and information about changes in legislation. The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. They were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or had any concerns. They told us that they would report any incidents or concerns they became aware of to the registered manager or a senior member of staff. The registered manager had attended the safeguarding 'threshold' training provided by the local authority. This provided a monitoring system for managers to help them identify which incidents required managing in-house, and which incidents needed to be reported to the safeguarding adult's team.

Staff told us that they only used restraint as "A last resort" and that they had recently carried out refresher training on 'Positive responses to behaviour', which helped them manage situations without having to use restraint. Staff said that one person was having one to one support and that incidents where restraint might be needed had reduced considerably. We saw that there was a 'restrictive physical intervention form' ready for use should it be needed.

We checked a selection of incident forms and saw that both accidents and safeguarding incidents were recorded. The safeguarding threshold tool introduced by the local authority had been used. The records included information about any investigation that had been carried out and the outcome. We saw that, when a person had been involved in an accident or incident, a copy of the accident or incident form was stored in their care plan. The registered manager told us that she checked accident records to monitor if there were any areas for improvement or to identify whether any patterns were emerging.

We saw that care plans listed the risks associated with each person's care and support needs. People had risk assessments in place about communication, medication, dignity and personal care, mobility, moving and handling, awareness of danger, epilepsy, fire, community and personal interaction. Some people had more specific risk assessments in place for areas such as dysphagia, hoarding food and use of a cocoon sleep system. Risk assessments recorded the problem, the identified risk, management of the risk and 'any other comments'. We saw that risk assessments were reviewed on a regular basis to ensure they remained relevant to the person concerned. We also saw that care plans included details of how to use equipment safely, such as "My bed rails need to be up and my bed moved to its lowest position."

The medication folder included the home's medication policy and procedure, a 'medication incident' report form where any medication errors could be recorded, protocols for 'as and when required' (PRN) medication, a recording sheet to list homely remedies, a self-medication risk assessment and screening tool, and specific information about the use of antacid medication and Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered.

Only senior staff working at the home assisted people to take their medication and training records evidenced these people had undertaken training on the administration of medication, although refresher training for four staff was overdue. We saw that a competency check form had been developed so that the registered manager could check that staff remained competent to administer medication, although these checks had yet to commence.

We spoke with a senior member of staff who explained the home's medication procedures to us. We saw that people had a lockable cupboard in their bedroom where their own medication was stored, and the medication administration record (MAR) chart was stored in the same cupboard. This reduced the risk of errors occurring, as medication was administered to people in their own room with no other distractions. We saw that each cupboard had a thermometer inside so that the temperature of the area where medication was stored could be monitored. We noted that temperatures were recorded consistently and that they were within recommended parameters.

We checked the MAR charts for two people who lived at the home. We saw that codes to indicate why some medications had not been administered were used appropriately and that there were no gaps in recording. Some handwritten entries had not been signed by two people. This is recommended to reduce the risks of errors occurring when information is transcribed from labels on to the MAR chart. There were protocols in place in respect of PRN medication; these were held with medication records and in care plans. One person's care plan recorded that they required PRN medication for hay fever and for pain. Records also detailed when medicine needed to be 'thickened', information about food supplements, the reason creams had been prescribed and 'How I like to take my medication'. One person needed their liquid medication to be thickened to help them to swallow it without choking; we saw staff thickening their medicine before administering it on the day of the inspection.

None of the people who currently lived at the home were prescribed controlled drugs (CDs). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered.

There was no audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Senior staff told us that they would ensure that a copy of the original prescription was obtained in future so they could ensure the medication delivered by the pharmacy was the same as the medication prescribed by the GP. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS)]. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that prospective employees completed a piece of written work as part of the interview process; this was to measure their report writing skills as this was a skill required for the role of care workers and above. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These

checks meant that only people who were considered safe to work with vulnerable adults had been employed at New House.

On the day of the inspection there was the registered manager, three care officers and a domestic assistant on duty, and one person who lived at the home was out with the person who provided them with one to one support. We were told there was one member of 'waking' night staff on duty each night and the records we saw confirmed this. We looked at staff rotas and saw that staffing levels were flexible so the needs of people who lived at the home could be met. Staff told us that they sometimes struggled to cover shifts, as the organisation's list of casual staff was depleted. However, they said that they had a "Great staff team" who would cover shifts at short notice and that staff from the care service next door would assist if needed, as well as the registered manager. This meant that the required staffing levels had been maintained.

We looked at service certificates to check whether the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, portable appliances, and hoists and slings. In-house checks took place on wheelchairs, water temperatures and first aid equipment / boxes, and 'visual' bed rail checks were also being carried out.

There was an Arson risk assessment and a Fire risk assessment in place. An annual fire test had been carried out on 23 February 2016 and annual fire drills were carried out to check that people who lived and worked at the home understood what action to take in the event of a fire; the most recent fire drill was held in March 2015. A weekly fire safety check was being carried out (although records indicated that this was actually fortnightly rather than weekly), and a monthly fire safety inspection was completed. In addition to this, the fire alarm system was tested in-house each week, as well as checks on fire extinguishers and fire sprinklers. Emergency lighting was checked each month. This showed that the fire safety arrangements in place at the home were robust.

There was a business continuity plan in place that advised staff on the action to take in the event of a flu pandemic, severe weather conditions, IT problems and lack of staff. We discussed how it would be useful to include information about power failures. The folder included staff contact details, details of the support needs of people who lived at the home and information about alternative accommodation. There was also a personal emergency evacuation plan (PEEP) in place that recorded each person's sensory impairment, any equipment used to mobilise and the assistance they would need to leave the premises in the event of an emergency. We saw that there was a pictorial notice on each floor that advised people what to do in the event of an emergency.

We walked around the building and saw that communal areas of the home, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. However, we noted that people stored toiletries on their bedside tables and doors were left unlocked. We discussed how it would be safer for these to be kept out of view as, although it was unlikely in this service, there was a danger people could mistake some toiletries for sweets or drinks. Staff told us this would be actioned immediately.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. One person's care plan recorded a capacity assessment that had been completed in respect of them managing their own finances.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We found that the registered manager displayed a good understanding of their roles and responsibilities regarding MCA and DoLS, and promoting people's human rights. We saw that one person's care plan included the documents to record a DoLS authorisation that was valid until February 2017.

We saw that care plans evidenced a person's capacity had been assessed and their ability to make decisions considered. Staff explained how they helped people to make day to day decisions; they explained choices to people and showed them different options of meals and clothes. One member of staff said, "We just do it naturally – like showing different clothes to people." One person who lived at the home told us, "I can choose things. I can get up when I want and go to bed at any time. I can make my own decisions."

On the day of the inspection we saw that staff consulted with people before they helped them with care. When people were able to consent they had completed a 'Consent to share information with others about my support needs' form. When people had the capacity to consent but were not able to sign the form, staff had recorded, "Discussed and agreed with [Name]." When people had been assessed as not having the capacity to consent to their care, best interest meetings or decision had been made. We saw best interest decisions had been made for areas such as health screening, receiving a flu injection, money for shopping, moving rooms, referral to health care professionals, and the use of mobility equipment. One person's care plan recorded, "As I cannot tell you verbally about the choices I want to make about my personal care needs and my social needs, please support me with any choices or decisions to be made, in my best interests, with consideration for the MCA 2005 and DoLS."

We saw that new staff carried out induction training over a three day period and also shadowed experienced staff as part of their induction; they worked over all shifts so they gained experience of people's care needs at different times of the day. We noted that one casual care worker who had no previous experience of working in a caring role had not completed induction training prior to commencing work at the home. This was acknowledged by the registered manager who told us that further training would be organised for this member of staff. They added that, in future, they would ensure casual staff undertook induction training before they worked unsupervised. The registered manager explained that other casual staff who were already employed at the home had received appropriate training, as they had been permanent employees

of the service who had left but remained on the 'casual' list. They also said that all new staff would be completing the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

The registered manager had defined what they considered to be essential training, specialist training and service specific training. Essential training included the topics of infection control, moving and handling, positive responses to behaviour, eating / drinking / diet / nutrition, food safety, first aid, fire safety, safeguarding adults from abuse and MCA / DoLS. All staff (apart from casual staff) had completed training on safeguarding adults from abuse, food safety and fire safety and most people had completed other essential training. Some refresher training was overdue and this was acknowledged by the registered manager. Staff told us they had attended a variety of training courses in the last year; these included moving and handling, physical intervention, record keeping, dementia awareness, fire safety and first aid.

Specialist training included equality and diversity, end of life care, falls prevention and data protection. Senior staff had attended training on safer recruitment, supervision and managing safety.

Staff also had individual training records in place that evaluated the training they had completed during the previous six months. One staff member's evaluation recorded that they had completed training on understanding dementia and food safety in the previous six months and needed to undertake training on safer recruitment and selection and moving and handling refresher training by May 2016. Another member of staff had attended training on managing well-being in the workplace, understanding dementia and moving and handling and needed to undertake training on supervision, positive responses to behaviour, risk assessment and learning disability awareness in the following six months. We observed that staff had the skills they needed to carry out their roles.

The registered manager told us that they aimed to have supervision meetings with people every three months. We saw the records of some supervision meetings and noted they included information about performance reviews, workload issues, individuals who lived at the home, safeguarding and well-being. The registered manager said they were in the process of introducing 'observed' supervisions to be held on a six-monthly basis and that moving and handling competency checks had already been introduced. The staff who we spoke with confirmed this. Staff told us they were well supported and "Could speak to the registered manager."

We saw the 'handover' sheets that were used to record any information that needed to be shared with staff on the next shift. This included the names of the staff on shift including the staff member who was providing one to one support. When a specific person was discussed, their initials were used instead of their name to protect confidentiality. Any appointments, rota issues, medication issues, sickness absence and messages were recorded and discussed. This meant that staff had up to date information about each person who lived at the home.

We observed the lunchtime experience; people were offered a variety of choices and individual meals were prepared for people. Several options were offered to people who were reluctant to eat. When people required assistance to eat their meal, this was provided on a one to one basis by staff. People told us they liked the meals at the home and one person said, "The meals are quite nice. They [the staff] know what I like."

Nutritional assessments and risk assessments had been carried out. One person's care plan included a mealtime prescription that had been developed by a speech and language therapist (SALT); this included diagrams to show the best body position and techniques to be used to promote safe eating and drinking.

Staff told us that any special dietary needs were shared with the cook and we noted that the cook delivered the meals to the home from a central kitchen and it was clear they knew people's individual requirements.

Food and fluid charts were used for some people to monitor their food and fluid intake. Some people's fluid intake was being measured in millilitres (as requested by the dietician) and some were recorded in mugs / cups as fluid intake did not need to be recorded in exact detail. People's food supplements were also recorded and any occasions when a person coughed whilst eating was being recorded as requested by SALT. People were also being weighed on a regular basis as part of nutritional screening. These arrangements enabled staff to monitor people's nutritional well-being.

People told us that they could see their GP when they needed to. They said they sometimes went to the GP surgery or sometimes the GP visited them at New House. We saw that any contact with health care professionals was recorded; this included the reason for the contact and the outcome. People's records included advice that had been sought from health care professionals, such as occupational therapist (OTs), physiotherapists, dentists and SALT. One person's care plan recorded, "I need help with my diet. My SALT assessment includes photos and a texture modification chart." We saw that people also had appointments with chiropodists and manicurists, and had hand massages.

People had hospital passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that hospital passports included detailed information under the headings 'Things you must know about me', 'Things that are important to me' and 'My likes and dislikes'. Another document was entitled 'This is about My Health'. This included details of health care professionals who were involved in the person's care, any allergies and support the person would need to attend hospital admissions and appointments. In addition to this, people had epilepsy management plans (including records of any seizures) and 'mini' health action plans in place; these were in symbol format to help people understand the content.

We saw that those people who could move around the home unaided could find their way around the home easily; one person helped us find the stairs from the ground to the first floor. People had names and / or pictures on their doors to help them locate their bedrooms. There was a lift to enable people to access the first floor. This was located in the hall / corridor area between New House and the adjoining property. This meant people had to leave New House to access the lift to the first floor and it was acknowledged by people who lived at the home and staff that this arrangement was not ideal.

Good

Is the service caring?

Our findings

People who we spoke with said they felt staff cared about them. This was confirmed by the staff who we spoke with. One member of staff said, "Yes, the people who live here always come first" and "Yes, I love working here – they are a good staff team – we all care." We observed positive relationships between people who lived at the home and staff.

Staff explained to us how they respected people's privacy and dignity. Their comments included, "We explain what we are doing", "We close curtains and blinds - we keep people covered up during assistance with personal care and make sure no-one else is around" and "We always knock on doors." We saw that people's bedrooms had enough space to enable them to see visitors and health care professionals in private.

We saw documents entitled 'How to achieve dignity status in care homes', a dignity audit tool, the Dignity in Care campaign and a dignity workshop pack. All of the information was used to promote the principles of dignity to staff working at the home.

People's care plans recorded information about the tasks they could do without help under the heading, "This is what I can do for myself." Staff told us they they promoted independence. One staff member said, "We just do what they can't do." One person had a fridge in their bedroom where they could store their own drinks and snacks. They also regularly made entries in their own daily diary sheets about the activities they had taken part in that day.

On the day of the inspection one person said they were tired and they laid on the settee. Staff got them a pillow and a blanket and they were left to sleep. When the person's lunch was delivered they were still asleep; it was reheated for them in the microwave when they woke up. This showed that routines were flexible to meet the needs of people who lived at the home.

There were no formal advocacy arrangements in place but the registered manager told us that a care manager was currently trying to source an advocate for one person following their recent care review. They said that another person's parents acted as their advocate. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. A pre-admission assessment had been completed prior to the person moving into the home; this covered areas such as nutrition, how the person liked to be supported with personal care needs, finances, mobility and general health. This information had been developed into an individual plan of care.

Care plans included a document called 'This is about me' that contained a current photograph of the person plus information about the key people in their life, their day and night time routines and information about how they communicated. We saw that under the heading 'Other things you need to know about me" the person's culture, possessions, personal relationships, life history and 'My hopes and dreams for the future' were listed. We noted that this document included symbols as well as words to assist people in understanding the information recorded. People's likes and dislikes were clearly recorded including what they liked to eat and how they liked to spend their birthday and Christmas.

Care plans were reviewed and updated each month to ensure they were up to date, and more formal reviews had been organised by care managers to review the whole care plan. Key workers prepared information ready for the annual review. Any changes in a person's care needs were recorded on an 'individual care amendment' form, such as changes in medication.

Some people who lived at the home could not verbally communicate their needs to staff. In these instances, care plans recorded the signs that staff needed to look out for and what they might mean. One care plan recorded, "If I am smiling or laughing I am in a happy mood and content with my surroundings." Staff told us, "We would know if people were not well or unhappy. One person uses facial expressions."

We saw the daily handover book that was used by staff to record the latest information about people who lived at the home. There was a day and an evening handover sheet, and we saw that each person's name was listed and a brief entry had been made to pass on information for the next shift. The form also recorded the names of the staff on duty, any messages in respect of people's medication and information received from or about involvement with outside agencies. In addition, the form had a second checklist to confirm that people's medication had been administered at breakfast, lunch and tea-time.

We saw that people could choose how to spend their days. People told us what they enjoyed doing, such as helping with tidying their bedroom and other household tasks. One person told us they were attending an Arts and Crafts class that afternoon, they went to church on a Sunday, their relative visited on one day a week and they were going away for a week the following week. One person was out with their one to one care worker on the day of the inspection and another person was out at a work placement. People were supported to keep in touch with family and friends. One staff member said, "Families do visit, and we help people to send birthday cards and Christmas cards."

We asked people if they felt they had choice and control over their lives and they said that they did. Comments included, "I do what I want to do" and "I choose to have my meals in my room." Staff told us, "We

ask them and give them choice", "We ask them their choices – you get to know them" and "We encourage them to be independent, and support them to make decisions."

We saw that the local authority complaints procedure and the home's own complaints procedure were displayed in the home. There was a form ready for use to record complaints, comments and suggestions although records showed that there had been no formal complaints since November 2013. There was a 'grumbles' log in place and the most recent comment had been received in November 2014. The satisfaction log recorded that verbal thanks had been received from a person's family in January 2016 about the care given to their family member.

One person who lived at the home told us that they could raise issues and they were confident they would be dealt with. They said, "I know how to make a complaint" and "I would speak to staff if I had a problem – they would listen and try to help."

We saw the outcome of the survey for people who lived at the home that had taken place in December 2014. Feedback was given to people at the 'residents' meeting in January 2015. One question asked was, "If you are worried about something, is there someone at New House you can talk to." One person had responded, "I feel safe at my house." Other questions included, "Do you feel you can say what you want to happen to you at your meetings?" and "Can you go out when you want?" 100% of participants recorded "Yes" in response to all of the questions asked.

We saw the minutes of the most recent meeting held for people who lived at the home. The topics discussed included menu requests, resident news, complaints / grumbles, the weather and activities. Previous meetings had been held on 23 February and 9 February 2016. The minutes recorded that everyone was happy with the menu, the activities people would be taking part in during the following week (such as boccia and attending a social club), the activities people had taken part in the previous week (such as visits to the cinema, days out with family and shopping trips) and staff rotas (such as staff who would be on annual leave).

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) for a number of years; this meant the registered provider was meeting the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We had not received any notifications from the home during the previous twelve months. However, our discussions with the registered manager led us to believe that they had a clear understanding of when a notification needed to be submitted to CQC.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew about the specific needs of people living at New House. Staff described the registered manager as "Really good." One person added, "Everyone knows what they are doing and what is expected of them" and another told us, "She is consistent, approachable, always helpful and works hard." They felt that this inspired them to work hard and encouraged them to "Do their best" for the people they supported.

A 'stakeholder' survey had been carried out at the end of 2014. Responses had been analysed and feedback had been given to all participants in February 2015. The participants had responded "Yes" to all questions. A new 'stakeholder' survey had been issued in January 2016. A staff questionnaire had been distributed in February 2016. Both surveys were still on-going and the responses had not been collated or analysed.

Staff told us they attended staff meetings every two or three months. We saw the minutes of the meeting held in December 2015. Staff discussed Nutrition Mission training, nutritional information that needed to be added to care plans, the recording requirements if staff needed to use physical restraint and discussion about individuals who lived at the home. There were previous meetings in October, June and February 2015. Staff told us that information was shared with them at staff meetings but they could also make suggestions and raise issues, and that they were listened to.

The team objectives were recorded as, "Ensure good quality and safe accommodation provision for eight adults who have a learning disability and associated problems. Promoted the rights, independence, choice and social inclusion of people to enable them to live as independently as possible, by offering person-centred approaches with recognition given to the need for calculated risk."

The registered manager recorded a quarterly team report that included 'What's going well' (such as two new staff completing the care certificate), service challenges (such as staff sickness impacting on the staff cover

budget) and recent achievements (such as partnership working with Speech and Language Therapy team and family to find solutions to one service user's changing needs in respect of eating and drinking via best interest).

There was a quality monitoring action plan that included details of any surveys, staff meetings, meetings for people who lived at the home and audits that would be taking place. This recorded that care plans would be monitored each month, first aid boxes would be checked each week and staff rotas would be checked each week.

We saw a variety of audits were being carried out to monitor the safety of the service and whether the service was meeting people's assessed needs. These included a monthly health and safety environmental audit and a care audit tool. Every six months one person's records were checked, including their care plan plus any other records associated with their care and support. This was a holistic check based on 'a month in the life' of the person concerned.

Medication systems were audited each week. This included a check on medication cupboard temperatures, the amount of 'As and when required' (PRN) medication used, that the times of administration were correct, that expiry dates were checked and that the stock of 'boxed' medication was correct. Any areas that required improvement were recorded and actioned.

The environmental audit checked that all areas of the home (internal and external) were clean and tidy, and recorded any maintenance checks that had been carried out; the fire log book was also checked as part of this audit.

We asked staff to describe the culture of the service. One member of staff told us the home was "Happy, homely, comfortable" and that there was a relaxed atmosphere. Another member of staff said the home was "Friendly, loving, caring and homely" and that "The residents feel this is their home." Staff told us they would use the home's whistle blowing policy if needed, and that they were confident the registered manager would respect their confidentiality.

Staff told us that they would discuss any incidents that had occurred and try to look for ways to improve the situation. They said that issues were not 'brushed under the carpet' but discussed openly to try to find solutions. They gave us an example of how they had identified one person became anxious on a particular day and how their weekly activity programme was amended in an attempt to reduce their anxiety.