Pathway Healthcare Ltd

Cabot House

Inspection report

62 Brighton Road
Crawley
West Sussex
RH10 6SX

Tel: 01293536322
Website: www.pathwayhealthcare.org.uk

Date of inspection visit:
01 November 2016

Date of publication:
21 December 2016

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 1 November 2016 and was unannounced.

Cabot House provides accommodation and personal care for up to nine people with a learning disability and complex needs, including behaviour that challenges. Six people were supported at the service on the day of our visit and were aged from 18 to 40 years. They required support with personal care and had additional communication needs. Accommodation was arranged across three floors of a large house. The service is one of three residential care homes run by Pathway Healthcare Ltd, a specialist provider of care, support and housing services.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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 home is run.

We found the following areas of practice required improvement. The registered person had not 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. Providers should have this information readily available to them through the internal systems they are required to have to monitor and improve the quality of their service. The registered person had not supplied the requested information within the deadlines we provided.

Care documentation was not always adopted, completed or updated in a timely manner. The provider's policies and procedures about the care and support provided to a person were not followed or used consistently. There were detailed behaviour management plans in place and these included clear indicators and possible triggers to behaviours that challenged, methods used to diffuse situations and appropriate staff responses. However, documentation used in conjunction with the use of 'safe holds', to safely manage behaviours that might cause harm was not used by the management of the service.

People, their relatives and healthcare professionals were positive about the quality of care and support provided to people at the service. One relative told us, "They do really care for [my relative], I know they are happy. It's a worry because they are very vulnerable, but I have no concerns at all." Another relative said, "Staff know [my relative] really well. Their key worker is simply brilliant, so caring, but just so sensitive to needs and their change of moods." People's keyworkers worked to identify goals and achieve greater independence. The registered manager sought to involve people, relatives and healthcare professionals to ensure people received the support they required.

Staff had detailed knowledge of people's needs and had the skills to provide support effectively. The registered manager carried out regular supervision sessions and appraisals. Staff felt well supported and understood their roles and responsibilities to ensure a quality service was given. Staff understood how to

manage risks to people's health and welfare and supported them to develop and reach their full potential. Staff had guidance on how to increase choice and control, reduce restrictive practice and improve quality of life. One member of staff said, "It can sometimes be very difficult if people are not using verbal communication. It is about getting to know the person very well and understanding the differences in their body language, for example one person uses the same movement to say different things. We use people's individual communication methods and take the time to understand what people are telling us".

People and staff celebrated achievements and milestones, including birthdays and cultural calendar events. A relative of a person said, "They had an open day, they had everything there; entertainment, an ice cream van, there was lots on. It gave us the chance to get involved and to meet each other."

Staff supported people with the values of dignity and respect. Support plans contained documented assessments of people's individual needs and the support they required. People continued to take part in activities they enjoyed and were encouraged to try new experiences based on their individual interests and abilities. There were sufficient numbers of skilled staff to meet people's needs and support activities. A relative said, "My daughter is vulnerable and always will be, so it's important that she is safe and I do feel the staffing levels are impressively high."

Staff understood how to protect people from possible harm. Risk assessments were completed to identify environmental risk as well as some risks that were specific to people's complex support needs. Risks in relation to meeting emotional needs and well-being were also considered and there was guidance in place for staff to safely manage risks and support people, for example to reduce their anxiety and potential social isolation. Staff ensured people accessed healthcare services for advice, treatment and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The registered manager understood their responsibilities under the Mental Capacity Act 2005. Mental capacity assessments and decisions made in people's best interest were recorded.

People's relatives and staff told us the registered manager promoted a person centred approach to care and support. They were complimentary about the registered manager who they said demonstrated strong leadership and provided a hands-on approach to the support people received. One member of staff said, "I always think of this as a happy house. It has a homely feel and the people come first. The manager is very good, very supportive."

The provider and registered manager effectively used the audit systems in place to continually monitor the quality of the service to further improve the support people received and management functions of the service. The registered manager monitored incidents and accidents and put plans in place to prevent recurrence. The provider used a recruitment procedure that ensured people received support from staff vetted as suitable to work with vulnerable people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Cabot House was safe.

Staff received safeguarding training and knew how to take action in response to any concern that may arise about possible abuse.

Risks to people were regularly reviewed and staff supported people to live safely.

Staffing levels were sufficient to ensure people received the level of support they required.

Staff supported people to manage their medicines safely.

Is the service effective?

Good

Cabot House was effective.

People had access to healthcare professionals when they needed it.

Trained staff had the skills to effectively support people to meet their needs.

People were able to choose what they had to eat and drink and had a positive dining experience.

The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity. Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Cabot House was caring.

People's relatives praised staff for their caring and professional approach.

Staff knew the people they supported well including their preferences, likes and dislikes.

People and their representatives were encouraged to make decisions around their support.

People were able to make their feelings and needs known and were treated with dignity and respect.

Is the service responsive?

Good

Cabot House was responsive.

Care and support was personalised and tailored to people's individual needs and preferences.

Staff communicated with each other and the registered manager on a daily basis to ensure that information was shared about people's needs.

People's relatives told us they felt confident to raise any issues with staff and the registered manager and felt their concerns would be listened to.

Is the service well-led?

Requires Improvement

Cabot House was not consistently well led.

The registered person had not submitted 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.

Systems were available to monitor and develop the effectiveness of the service, however these were not always adopted and followed.

The registered manager was described as approachable and staff felt supported and valued.

The culture of the service was open and friendly.

The registered manager carried out quality assurance checks regularly in order to develop the service.

Cabot 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 checked 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.

We visited the service on the 1 November 2016. This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

During the inspection we spent time with people who lived at the service. We spent time in the lounge, kitchen and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted. People were unable to use structured language to communicate verbally with us, so we used 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.

We spoke with those that knew people well, we spoke with five relatives of people. We gained the views of staff and spoke with the registered manager and four support workers.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority and looked at the record of notifications. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we reviewed the records of the service. These included staff training records and procedures, audits and three staff files along with information about the upkeep of the premises. We looked at three support plans and risk assessments along with other relevant documentation to support our findings.

Good

Is the service safe?

Our findings

People were safe and the interaction between them and staff appeared comfortable and relaxed. The relative of one person told us, "You can tell when you take a young person back from a visit home, can't you? He's never unhappy about going back, he's not reluctant, this tells us everything. He is most definitely safe. There's never been any issues over safety." Risks for people were minimalised and they were enabled to try new experiences. The registered manager said, "Risk assessments have been completed for all clients to inform staff of any risks and also to enable people to safely take part in activities they enjoy."

There was safeguarding information called, 'Say No to Abuse' available for people and their visitors, this was displayed in the hall of the service. The guidance was in an accessible format and used pictures and words to convey the safeguarding message. Contact numbers for reporting concerns were clearly displayed. There were a number of policies to protect people's rights and keep them safe from harm. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy enables staff to raise concerns about their workplace to protect people from abuse. Records confirmed staff had received safeguarding training as part of their induction and this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One member of staff told us, "You have to have your eyes and ears open all the time and make sure that people are not being subjected to any kind of abuse or neglect. If I did have concerns I would report it and then go to head office if nothing was done. We have a whistleblowing policy".

Staffing levels were assessed in line with people's needs and were adjusted when the needs of people changed to ensure their safety. The registered manager told us, "Today we have five staff on shift. There is usually four on a Tuesday, but today we have five because of what activities we have on." Staff told us that there were enough staff and that staffing levels were increased if people needed additional support, for example, if they had scheduled social activities to attend. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that bank staff were called in when required. Feedback from people's relatives and staff indicated they felt the service had enough staff and our own observations supported this. A relative said, "My daughter is a vulnerable and always will be, so it's important that she is safe and I do feel the staffing levels are impressively high."

Risk assessments for people's healthcare needs were in place and regularly reviewed. For example, each person's support plan had a number of risk assessments which were specific to their needs and these included identified potential hazards for people, assessed the level of risk and the measures taken to reduce the risk. Staff were observed to follow the guidance throughout the day. Risks in relation to meeting emotional needs and well-being were also considered and there was guidance in place for staff to safely manage risks and support people, for example to reduce their anxiety and potential social isolation.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks were recorded and staff knew what action to take in the event of a fire. There was an emergency evacuation plan in place (PEEPS) for each person, these were individualised to

ensure risks were minimised for each person. Staff were aware of the plans and what action would be required in the event of the house having to be evacuated. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene and hazardous substances. There was a business continuity plan that provided a plan to staff on what to do in the event of the service not being able to function normally.

Accidents and incidents were recorded and monitored to identify patterns and trends and action had been taken to reduce the risk of the accident occurring again. For example, during a period when there was an increase in behaviour that challenged from a person, risk assessments and care plans were updated to reflect changes in their needs. Alongside these measures, their support requirements were reviewed and appropriate referrals to external healthcare professionals had been made.

Staff were trained in the administration of medicines. Staff described how they completed the medication administration records (MAR). Regular auditing of medicine procedures was undertaken to include checks on recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues were identified and addressed. Staff administered medicines sensitively and appropriately. A relative we spoke with voiced their confidence in the staff member's ability to safely administer medicines to their loved one. They told us, "They are very good about all health related matters, [my relatives] key worker is on the ball about their dental appointments, and they are monitoring her medication for her seizures. There's an appointment for the neurologist." Medicines were stored appropriately and securely and in line with legal requirements. Medicines were ordered in good time and those that were out of date or no longer needed were disposed of appropriately.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. The staff files we examined demonstrated that robust selection and recruitment practices were undertaken when new staff were recruited, this included an application form with full employment history, proof of identity and evidence of the formal interview. Two references and a Disclosure and Barring service form (DBS) were taken before new staff began employment. A new member of staff that was undertaking their first day of induction told us that they had not been able to take up post until all of the required documentation was in place. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Good

Is the service effective?

Our findings

People had access to health and social care professionals when required, these included GPs, learning disability nurses and speech and language therapists (SALT). People had health plans that described the support they needed to stay healthy. Established staff knew people and were able to recognise any changes in their behaviour or demeanour and ensured they received appropriate support in response to noted changes. Staff told us they felt they had good relationship with local health professionals. Relatives told us staff ensured that people had access to medicines and healthcare professionals when they were not well. The relative of one person told us, "They support him well, they registered him with the local GP, and the special needs dentist. He doesn't like going there, but I know they are working on it."

People were supported by staff who had the necessary skills. There was a commitment to ongoing staff learning and development. New staff were supported to learn about the provider's policies and procedures as well as people's needs. Staff told us they had received induction training when they began work at the service and they had received up-to-date essential training. The provider's induction process was aligned with the requirements of the care certificate. The care certificate is an identified set of standards that health and social care workers adhered to in their daily working life. It covers the learning outcomes, competences and standards of behaviour that must be expected of support workers in health and care sectors and replaces previous common induction standards. A training matrix we examined showed that five staff were undertaking the care certificate award.

Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. They described an emphasis on training that was carried out face to face or on line. One member of staff told us, "There is training which we do regularly. If you need it, you can do it." The manager showed us a system for tracking and flagging when updated training was required. Staff received additional training that recognised the complex support needs of the people they supported, subjects included behaviour support for people with learning disabilities that looked to improve people's quality of life, increase choice and control and reduce potentially restrictive practice. Some staff had obtained the National Vocational Qualifications (NVQ).

People's food likes and dislikes were recorded in their care plans and in the kitchen. People's weight was monitored and records showed referrals were made to health care professionals if people's nutritional intake reduced or staff had any concerns around people's nutrition and hydration. People received sufficient quantities of food and drink and every effort was made to provide a choice in this essential aspect of daily living. For example, a person had an alternative for the lunch we observed. Staff told us this was because they did not like salad that was on the menu that day. People had access to snacks at any time. An extract from one person's care plan said, '[Named person] is a healthy 19 year old, growing man, he gets hungry. It is important that he has healthy snacks between meals. He loves cheese and staff should give him little chunks throughout the day.' One relative said: "It's lovely, they have the big table and they all sit down together. [My relative] is a bit fussy about their food, but they have worked around that. They also listen to me about what he likes and doesn't like. [My relative] keeps something similar to a tuck box, I occasionally send in the things as treats. The staff are good and just accept that we want to do that."

People's communication needs were assessed and met. Observations of staff interaction showed they adapted their communication style to meet people's needs. For example, we saw that a communication board was effectively used with one person to assist them making their choices known. We observed another person in the kitchen involved in preparing lunch with a staff member. We saw that one person did not eat their lunch and left it on the table. A staff member said they would come back again later as they did not like a lot of people around. When the room was quieter, the person came back and ate their lunch. A staff member sat with them and chatted until they had finished. A member of staff said, "It can sometimes be very difficult if people are not using verbal communication. It is about getting to know the person very well and understanding the differences in their body language, for example one person uses the same movement to say different things. We use people's individual communication methods and take the time to understand what people are telling us".

Effective communication also continued amongst the staff team. Regular handover and team meetings, as well as use of communication books, ensured that staff were provided with up to date information to enable them to effectively carry out their roles. For example, detailed shift planning sheets were in place for both day and night shifts that gave staff sufficient information to ensure that the support being offered was effective. The shift planners detailed how many staff were required to support each individual activity and there were sufficient staff to ensure that people's timetables were carried out.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was working within the principles of the MCA. They understood the requirements of this legislation and had acted in accordance with it and therefore ensured that people were not deprived of their liberty unlawfully. The registered manager had ensured that the least restrictive options were considered when supporting people who lacked capacity and whose behaviour challenged services. For example, while the front door was not locked, giving people access to the front garden, there was a keypad operated lock the front gate, supported by a DoLS application in place for its use.

Mental capacity assessments were decision specific and assessed the person's ability to understand the information related to the decision being made. Records showed how the decision of capacity was reached. The registered manager gave an example of a best interests meeting held with regard to a blood test for a person. They told us, "There was a best interests meeting held. Families and other professionals were involved. It was assessed if the people had the capacity to make a decision for themselves. We then went through the stages, starting with an assessment."

People were supported by staff who had access to appropriate support and guidance to carry out their role. Regular supervision meetings took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff supervisions were carried out by the registered manager. Records showed that supervisions and annual appraisals were recorded and kept on individual staff files. Staff said that they found supervision helpful and supportive and told us that, in addition to formal supervision, staff handovers and staff meetings were also used to discuss practice issues and offer staff support. One member of staff said, "I get to say what I want to say and [the registered manager] will listen and get back to me if the need is

there."

Good

Is the service caring?

Our findings

People were supported by staff that were kind and caring. Staff were aware of the needs of the people they were supporting and showed good anticipation of their needs. Observations demonstrated that positive and warm relationships had developed between people and staff. There were lots of smiles and laughter and people were very comfortable with the staff supporting them. Relatives told us, "They do really care for [my relative], I know they are happy. It's a worry because they are very vulnerable, but I have no concerns at all." Another relative said, "Staff know [my relative] really well. Their key worker is simply brilliant, so caring, but just so sensitive to needs and their change of moods."

There were positive and friendly interactions between people and staff. People could not tell us that they liked the staff and were happy, but we observed warmth and affection between people and staff. We observed interactions throughout the day. People had busy schedules that were suited to the pace of life they followed as young adults. People received one to one support and then came together as a group for events they all enjoyed. One relative said, "[Named person] settled down very quickly and I put this down to the staff and their attitude and the ethos of the organisation." Where it was required, staff took steps to help alleviate people's anxiety and ensured that they were not put in situations that would increase their stress. For example, a person found the noise levels at group based activities too much, so staff worked with alternatives, including one to one time. One relative told us, "There is a rapport and communication from staff that has been wonderful for [named person]".

Staff supported people in a timely, dignified and respectful way and this was embedded within their daily interactions with people. We saw regular, positive interaction between people and staff. We heard staff taking time to explain what they were doing clearly to people in a way that promoted inclusivity and understanding. Staff kept up a friendly enquiring dialogue with people even when they may not always get a clear response. For example, staff asked people about their level of comfort in response to the temperature in the room they were in. Staff and the registered manager asked the following questions before they offered support, "Is it ok if ...?", "Would you like me to...?" and "I wonder if we should get ready then? What do you think?"

People's differences were respected and staff adapted their approach to meet people's needs and preferences. Staff were aware of the needs of the people they were supporting and showed good anticipation of their needs. Each person's care plan documented their individual communication methods and these were followed by staff. For example, we observed how a person returned home from an activity and immediately became very vocal and showed signs of anxiety. A staff member used a timer with the person to help meet their anxiety. The timer was used an effective tool to display the passage of time. It was a powerful assistive tool for the person who struggled with the abstract and difficult concept of time. The member of staff told the person, "Its ok, lunch will be in forty five minutes, it's on the timer now." The person then visibly relaxed on the sofa. When we checked the person's care plan, this was an agreed strategy for staff to follow.

People were able to maintain their identity as young adults, they wore clothes that reflected who they were

as a person and their rooms were individually decorated, with personal belongings and items that were important to them. Diversity was respected and support plans showed that people were able to maintain their identity. Not only did care plans contain positive person centred profiles of each person, but there were also one page profiles of each member of staff. These informed people using the service and their families who each staff member was and how their skills, interests and hobbies were relevant to supporting people living at Cabot House.

People and their relatives were consulted about their wishes and support plans were reviewed in response to changes in needs. It was recognised that people needed additional support to have a say in their support and the registered manager had sought to involve people's relatives when it was appropriate. People were able to access an advocacy service. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Families said they had been involved in the planning of their relative's care and support and that the transitions into the service had been very thorough and well thought out. One relative said, "The transition from school was wonderful, they really worked in partnership with us and the school to get it right for [named person]. We do feel listened to." Relatives confirmed that they could approach staff if they had any questions or queries. A relative told us, "I feel I get on extremely well with the manager. I email or ring her. Things always get resolved, so if any little thing isn't right, I only have to ask once and it's sorted out."

People's privacy and dignity was respected. Staff respected people's right to privacy. For example, we observed that one person required support with an aspect of personal care. Staff went to the person and knelt beside them and spoke quietly and sensitively with them before taking them off to attend to their care. Staff were also observed knocking on people's doors before entering, to maintain people's privacy and dignity. Information held about people was kept confidential. Records were stored in locked cabinets and offices.

People were encouraged to maintain relationships with their family and friends. Relatives told us that they were able to visit the service and were made to feel welcome. They said they were able to visit at any time and were free to go to their relative's room if they wished or use the space in the communal areas.

Good

Is the service responsive?

Our findings

People's health, social and communication needs were assessed and support was provided to ensure that their needs were met. One relative said, "They really think about [my relatives] communication needs, they have his board downstairs in the dining room and they use 'Now & Next' and "Safe Place" cards. I'm really impressed, they worked with the speech therapist to help them."

There were enough staff to deliver person centred care. Staff acknowledged they were often busy, but told us they had enough time to spend one to one with people, to meet their physical, social and emotional needs. Observations showed that staff identified and met people's needs in a timely manner. Staff appeared to have sufficient time to spend time with people, engaging with them using voice and, where it was appropriate, reciprocating touch. Staff took time to gauge and respond to people's feelings and expressions of emotion. They demonstrated patience and understanding when supporting people and could interpret complex verbal and non-verbal signs that communicated, for example, anxiety, happiness or contentment. If a person showed signs of apparent anxiety they appeared to calm when member of staff took time to talk with them and seek to find the reason for their distress. A staff member commented, "You follow the guidelines and ensure that people are kept safe. We fill in the relevant forms and go to the office to de-brief. I think the situations are dealt with professionally and sensitively and we discuss how it can be prevented in the future".

People were encouraged to have daily routines to help improve or maintain their well-being and reduce the risk of social isolation. People were provided with a mix of activities and occupation through the day. As well as structured events, there were impromptu activities that took place in the service and which all the people were involved in, such as going out on errands or helping out around the house. Thought had gone into providing meaningful activities and sensory stimulation for people both in their own rooms and in the service's own sensory room. The provision of sensory equipment promoted well-being and quality of life for people wherever they spent time. When we asked relatives and visitors about the provision of activities, one person told us, "During the day there is a lot on, they go to the "Out There" centre, and if they don't want to do what's on the plan, they're not made to. So, then they might go for a walk, or a bus ride, so they get out a lot." Another relative said, "Without doubt, he has a great time and there are a whole range of activities. They go swimming, to Tilgate Park, horse riding, lots of things."

People's health and social care needs were assessed and met. People's relatives told us that they were able to talk to staff if they ever had any concerns about their loved one's support needs. People's needs were assessed when they first moved into the service. We looked at the care plan of a person who had recently moved to the service, it provided a detailed pre-admission assessment. There was also a transition plan implemented, with a 'transition checklist' completed on admission. Care plans detailed areas such as people's likes and dislikes, their emotional wellbeing, cultural and medical needs and how behaviours should be positively met and monitored. Care plans also contained clear communication plans and during the day we observed staff used each person's individual form of communication.

Support plans were devised to document the person's needs and abilities in relation to their needs. Plans

were reviewed and updated between reviews if changes occurred. Key workers reviewed support needs and sought feedback from other staff. They drew up and amended plans of support based on observations of people and changes in their needs throughout the period under review. The registered manager acknowledged the difficulties faced when seeking to involve people in the review process. A relative told us their experience, "They are very flexible and responsive, they have already adapted things for him in a very short time. They changed his room, brought in new flooring, and sorted out his sound system, they keep him busy which he needs." Reviews captured changes in people's needs and changes were reflected in plans of support. For example, an assessment by a health care professional provided clear, detailed guidance for staff to follow in relation to the support needs of a person and staff had implemented these recommendations.

People were supported, whenever possible, to make choices in their everyday life and their individuality was respected. Observations showed staff respected people's wishes with regards to what time they wanted to get up, what clothes they preferred to wear, what they did with their social time and what they had to eat and drink. People's rooms reflected their personalities and interests and people were able to furnish them according to their taste with their own art and family photographs on display.

There was a complaints policy in place. A process was in place for recording complaints that had been made. The registered manager encouraged feedback from people's relatives. Information was displayed in an easy read format that informed of their right to make comments and complaints about support received. Relatives told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager. One relative told us, "In the past there were issues, but the new manager has sorted these out, so I suppose it never really got as far as far as a formal complaint. The new manager has worked hard to improve communication."

Requires Improvement

Is the service well-led?

Our findings

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Providers should have this information readily available to them through the internal systems they are required to have to monitor and improve the quality of their service. The provider had not supplied the requested information within the deadlines we provided. We have identified this as an area of practice that needs improvement.

The provider's policies and procedures documentation about the care and support provided to a person were not followed or used consistently. One person's care file contained a risk assessment and guidelines for the use of 'safe holds'. The physical restraint was one method used to safely manage behaviours that might cause harm to the person or others. A document was available to record all decisions and occasions when the method was used but it had not been used for this person. If used as directed it would guide staff to record detail such as how many staff were involved, identify the staff that used the interventions and record the length of time the hold continued. This would ensure that there was learning each time the practice was used and help ensure that the safest method possible to restrain the individual was used. We have identified this as an area of practice that needs improvement.

People's relatives and staff were complimentary about the management of the service. They told us that the registered manager was available, approachable and friendly. One member of staff told us, "I always think of this as a happy house. It has a homely feel and the people come first. The manager is very good, very supportive". A relative told us, "I am delighted with the manager and the team. We're really impressed with everything, so much so, that [person's sibling] is also moving into Cabot in the New Year."

Part of a registered manager's responsibilities under their registration with the Care Quality Commission is to consider guidance in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. Regulations relate to the registered manager's responsibility to notify us of certain events or information. Registered managers' are required to inform CQC to enable us to have oversight to help ensure that appropriate actions were followed and to ensure people's safety. The registered manager had notified us of events that had occurred within the home so that we could have an awareness and oversight to ensure that appropriate actions had been taken.

There were robust quality assurance systems and processes within the service. A range of quality assurance audits took place to ensure that the systems and processes used were effective. They helped to identify areas of practice that were working well and also those that needed improvement. They monitored the quality of the service in such areas as infection control, medicines, care records and the environment and were used to effect change. The registered manager undertook these quality assurance processes and they were supplemented by audits and review of service by the provider. The last provider audit dated from April 2016 and resulted in, for example, changes to the recording of risk assessments and the way that people's feedback was sought.

The registered manager was visible and active within the service. They told us, "I have an open door policy." In turn, the registered manager felt supported by the provider's management structure. They said, "I can pick up the phone and speak to people. There's always someone there for support and advice with a network of people to draw on." The service had a strong emphasis on teamwork and communication sharing. There were open and transparent methods of communication. There was a communication book in which key messages were left and daily handovers for staff. This kept staff informed of any developments or changes to people's needs. One member of staff told us, "The manager is very relaxed and approachable, she also does not get flustered which is good for us. She is someone you can talk issues through with and she cares a lot about the clients and the staff."

The provider encouraged best practice to be shared among their services. For example, on the day of our unannounced visit, the manager of another service was in the building learning and sharing their experiences. Recommendations and learning informed quality and practice within the service. The registered manager met regularly with other managers to keep up to date with current practice and guidance. Additionally, reports submitted by the registered manager were monitored by the provider's management team. There were links with external organisations to ensure that the staff were providing the most effective support for people. By forging links with outside organisations such as the local authority and healthcare professionals, staff were able to learn from other sources of expertise.

The registered manager described the vision and aims of the service. They emphasised openness and transparency in how the service provided support and care to people. They told us, "As a staff team we all excel in individual areas and have other areas where we may need more support, but we try to do this in a positive way so that we pick up on areas of people's strengths. We have a no blame culture. For instance, in the last team meeting we discussed how we are one team." They were aware of the statutory Duty of Candour that aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. They described the aspiration to support people to meet their individual needs and encourage confidence. The values were seen to be reflected in the service in that it had a relaxed and homely feel and people appeared to be happy and content. Staff were encouraged to ask questions and provide input into the management of the home. The following feedback from a member of staff about the leadership of the service was noted, "I am very happy with the management of this home. The manager is trying to build a good team".