Voyage 1 Limited

Mountain Ash

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

Mountain Ash provides residential care for up to 10 young people with learning and physical disabilities. There were eight people living in the home at the time of inspection. Seven people had complex communication needs and everyone required staff who knew them well to meet their needs. People's needs were varied and included requiring support associated with cerebral palsy, epilepsy and diabetes.

The home was purpose built, all the rooms were on the ground floor and there was a large secure garden, which was easily accessible for people using wheelchairs.

There was 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.

This comprehensive unannounced inspection took place on 4 and 9 November 2016.

There were enough staff who had been appropriately recruited, to meet the needs of people. Staff had a good understanding of the risks associated with supporting people. They knew what actions to take to mitigate these risks and provide a safe environment for people to live. Staff understood what they needed to do to protect people from the risk of abuse. Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

The manager and staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They had assessed that restrictions were required to keep people safe. This related to the need for locks on the kitchen door and to the entrance of the pool area. It also meant that those who needed bed rails or lap belts on wheelchairs had them. Appropriate referrals had been made to the local authority for authorisation.

Staff had a good understanding of people as individuals, their needs and interests. Some people attended day centres, activities were provided within and outside of the home daily, and people were supported individually to have their needs met. The sensory room had been redecorated and this offered a relaxing and calming area for people to spend time. There is a hydro pool on site. Over the past few months a number of problems had prevented its use. However, when available this presents a regular and enjoyable activity option for people.

There were safe procedures in place for the management of medicines. People had access to healthcare professionals when they needed specific support. This included GP's, dentists and opticians. Where specialist healthcare was required, for example, from a physiotherapist or speech and language therapist, arrangements were made for this to happen and detailed guidelines were provided. This meant that if people had been prescribed particular exercises, records showed why they were needed, what would

happen if they were not carried out. Along with detailed instructions, there were photographs of the equipment to be used and how it was to be used. This meant that staff had the knowledge to support people effectively.

People were asked for their permission before staff assisted them with care or support. Staff were skilled in identifying people's various ways of communicating. They knew the various sounds and indicators people used to make their needs known and we saw that people reacted positively when staff responded to them.

Staff had the skills and knowledge necessary to provide people with safe and effective care. Training was provided which was specific to meeting people's complex needs. Staff received regular supervision and support from management which made them feel valued. Staff spoke positively about the way the service was managed and the open style of management. Staff told us, "The manager has the service users and home's best interests at heart. They keep everyone up to date and check that service users receive good quality care."

The provider had strong systems to monitor the management and quality of the home and through regular internal monitoring the registered manager ensured that a range of audits were carried out to monitor the care and support provided. Where shortfalls were identified action plans were draw up and matters were addressed in a timely manner. There was a continual system of review and evaluation to drive improvement.

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's medicines were stored, administered and disposed of safely.

There were risk assessments in place and staff had a good understanding of the risks associated with the people they supported.

Recruitment procedures were in place to ensure only suitable people worked at the home. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff sought people's consent before providing all aspects of care and support. Staff received specialist training to support people effectively.

People were supported to access a range of health care professionals to help ensure that their general health was maintained. Support was provided in the way people wanted to receive it.

The manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and respect.

Staff knew people well and displayed kindness and compassion when supporting people. People's dignity and privacy was promoted.

Staff adapted their approach to meet people's individual needs

and to ensure that care was provided in a way that met their particular needs and wishes.

Is the service responsive?

Good

The service was responsive.

People received support that was responsive to their needs because staff knew them well and support plans also contained guidance to ensure staff knew how to support people.

Staff were skilled in identifying when people wanted change or were unhappy and responded to their needs promptly.

People were supported to take part in activities of their choice.

Is the service well-led?

Good

The service was well-led.

Statutory notifications were submitted to the Care Quality Commission when appropriate.

A wide range of audits were carried out to monitor the running of the home and to ensure that it was well run.

There was a positive and open culture at the home. Staff told us the registered manager was supportive and approachable. They were readily available and responded to what people and staff told them.

Mountain Ash

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.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We considered information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

This inspection took place on 4 and 9 November 2016 and was unannounced. The inspection was carried out by one inspector 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.

Most people who lived at Mountain Ash were unable to verbally share with us their experience of life at the home because of their disabilities. Therefore the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watched how people were being cared for by staff in communal areas. This included the lunchtime meals. We also 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. During the inspection we met with a relative of one person. We also met with the registered manager, the operations director, a senior carer and two care staff.

During the inspection we reviewed the records of the home. This included staff recruitment, training and supervision records, medicines records, complaint records, accidents and incidents, quality audits and policies and procedures, along with information in regard to the upkeep of the premises. We also looked at three people's support plans and risk assessments along with other relevant documentation.

Good

Is the service safe?

Our findings

When people needed support there was always a member of staff available to provide reassurance and guidance where appropriate. For example, when people were supported moving around Mountain Ash, staff explained clearly what they were doing and gave regular reassurance to help them to feel safe and secure.

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in a cupboard which was in a locked room. There was advice on the medication administration records (MAR) about how people chose to take their medicines. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they experienced pain. A copy of each person's PRN protocols were stored within the MAR charts. Not everybody who experienced pain was able to express this verbally, and there was information in people's care plans about how they may express they were in pain. Although only senior staff gave medicines within the home, all staff completed training on the subject. The temperature at which medicines were stored in a fridge were recorded daily but there were no room temperatures recorded to ensure that medicines were stored at a safe temperature. The registered manager said this was an oversight and a record sheet had been started by the second day of our inspection.

There were enough staff working in the home to meet people's needs safely. There were clear on call arrangements for evening and weekends and staff knew who to call in an emergency. Staff told us there were enough staff to meet people's individual needs. There were two staff vacancies and these posts had been advertised. In the interim part time staff were working extra hours and bank staff were used. One staff member had been appointed and was due to start subject to satisfactory recruitment checks.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a range of documentation including photo identification, written references and evidence that a Disclosure and Barring System (police) check had been carried out to ensure people were safe to work in the care sector.

People were protected against the risks of harm and abuse because staff had an understanding of different types of abuse and knew what action they should take if they believed people were at risk. Risk assessment documentation in care plans had been updated at regular intervals and always following an incident. Staff told us that when an incident occurred they reported it to the registered manager who was responsible for referring the matter to the local safeguarding authority. When an incident or accident occurred staff completed a form which described the incident and how it had been resolved. Records related to incidents had been documented well and where appropriate, matters had been reported to the local authority for further advice and support.

There were strategies to mitigate any risks identified. For example, people who were at risk of choking had guidelines to make sure that staff knew how to minimise the risk of this happening. We observed that food was offered in a way that suited each person and staff supported people to eat slowly and ensured that people did not have too much food in their mouths at any one time. If people ate too quickly staff advised

people to slow down and if necessary, used a light touch on the backs of people's hands to slow them down.

Regular health and safety checks ensured people's safety was maintained. Weekly safety checks were carried out on wheelchairs, lap belts and bed rails to ensure they were in good order. Other checks included infection control and cleaning checks, gas and electrical servicing, legionella testing, vehicle testing and portable appliance testing. All staff had received fire safety training and people had personal emergency evacuation plans. They contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. There were regular fire safety checks in place including fire drills and staff were clear about what they should do in the event of a fire. A fire risk assessment was completed in February 2016 and a fire safety audit was carried out in July 2016. Whilst fire drills were carried out regularly, these were planned drills and there was no procedure in place to sound alarms for an unplanned drill to test that staff knew what to do in the event of a fire. This is an area for improvement.

Good

Is the service effective?

Our findings

People received support from staff that knew them well and had an understanding of how to support them appropriately. People's health needs were met and there were good systems in place to ensure people attended a range of healthcare appointments.

Staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and there was appropriate documentation in place. There were locks to certain doors such as the kitchen and the pool area. People used lap belts on wheelchairs and some had bed rails for their safety. Where appropriate, standard authorisations were in place and staff understood why people had restrictions as this was clearly stated in care plans and risk assessment documentation.

Staff asked people's consent before providing support. Consent forms were included within people's care plans and if people had been assessed as unable to provide consent this had been discussed with their relatives and representatives. We observed staff supporting people and seeking their consent. One person was able to give verbal consent. Another person when presented with two choices was able to make a decision. For example, the staff member showed two hands and each hand represented a particular choice. The person was able to point to the hand that represented their choice. We saw on two occasions that staff responded to people who made vocal sounds and they took them to a different environment where they settled. Staff told us that it took time to get to know people, to understand their facial expressions and vocalisations and how they expressed their needs. They said sometimes it was a process of elimination to identify what was wrong but they persisted until people were settled. Care plans clearly explained how people expressed their views and what difference vocalisations might mean for different people.

Where people lacked capacity to consent, best interests decisions were taken. For example in relation to flu vaccinations the home had sought advice from their local GP. Two people had advocates who represented their views at annual reviews and the registered manager was clear that they would contact them if any best interests decisions needed to be taken.

There was a commitment to ensuring staff had the necessary skills to carry out their roles effectively. There was a training programme and records showed that 98% of staff had completed all mandatory training and

dates had been booked for the remaining staff to complete this. Staff told us they received training which included safeguarding, mental capacity and DoLS, infection control and food hygiene. A staff member told us that as they completed e-learning training they completed questionnaires and talked to the registered manager if they were unclear about any aspect.

Systems were in place to ensure staff received appropriate training to maintain competence in their role. We asked if staff had received any specific training to meet the needs of people living at Mountain Ash. Staff had completed essential training on diabetes, epilepsy and lifeguard training. Since the last inspection staff had completed training on cerebral palsy and on learning disabilities. This was the first time that the course had been run at the home. The registered manager told us that feedback from staff had been mixed. New staff had thought the course was very informative but staff that had worked in the home for some time had gained less from the course. The registered manager said feedback had been given to the trainers and as a result a more in-depth course had been booked for new staff to attend. This showed the home was striving to drive improvement to ensure staff had the skills they needed in their role.

Staff had specialist knowledge to meet peoples' needs effectively. We asked a staff member how cerebral palsy affected one person. The staff member had in-depth knowledge of how cerebral palsy affected the person and how staff supported the person to prevent contractures (a contracture is a permanent shortening of a muscle, tendon or ligament which causes the loss of mobility in the affected joint). They talked about the equipment used by this person and the importance of correct positioning to support their posture. They knew why specialist cutlery was used at mealtimes and the importance of adding thickener to drinks to prevent the risk of choking.

As part of the commitment to ongoing training, 14 of the 21staff had completed a health related qualification at level three or above and another two staff were in the process of studying for a level two qualification. Staff told us that the training provided equipped them to meet people's needs. We observed staff supporting people appropriately with their moving and handling needs throughout the inspection. One person needed the hoist to transfer to another chair. Staff explained the procedure, supported the person, and reassured them throughout. The registered manager ensured staff had the opportunity to participate in training appropriate to their role.

There was a structured induction programme for new staff to make sure they knew what was expected of them in their role. This included time to get to know people, to read their support plans and to shadow other staff. An in-house induction checklist was completed to ensure that staff knew the home's procedures. On completion, staff who had not previously worked in care went on to complete the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff that are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

There were effective systems to enable new staff to develop competence in their role. A staff member told us that the induction was very thorough and that they were, "definitely supported." They said, "I had hoist and moving and handling training within the first week. I've completed most of my mandatory training." The staff member told us that as part of their probationary period, they observed an experienced staff member when they provided support to each person. They then were observed supporting people. They were given feedback about what went well and what did not go so well and were not signed off until they had been assessed as competent with each person. The registered manager told us that whilst this was the practice, and there was an induction checklist completed, the record keeping to demonstrate the service specific induction was not yet up and running. However, the new format had been developed and was ready to use for the next staff member recruited. As part of the process, a recently recruited staff member had written a

list of information that would be useful for a new staff member to know. We were told that this information would also be made available to all staff.

Systems to ensure staff receive appropriate support; supervision and appraisal to make sure competence in their role were maintained. Staff received regular supervision which was booked in advance and they told us they were able to have extra supervision if they required further support. All staff spoke positively of the registered manager. A staff member told us, "The support is 100%." Another staff member said, "I've always been supported and we all work together as a team."

Menus were planned one week in advance. We were told that alternatives to the main menu were available but people rarely chose an alternative as they menus were designed around people's known preferences. Staff told us that whilst most people could not verbally tell them if they did not want a meal, each person was able to indicate either through vocal or facial expressions, pushing food away or leaving the table that they did not want a particular meal. Sometimes a different staff member tried to support a person with a meal and if the person still did not want the meal an alternative was provided. We saw that this was the procedure followed at lunch time and one person had a different meal.

People were supported to maintain good health and received on-going healthcare support. Everybody had a health action plan that identified the health professionals involved in their care for example, the GP, physiotherapist, speech and language therapist and dentist. Health action plans contained important information about the person's health needs. In addition there was a care passport that would be used should anyone need to be admitted to hospital. They included information such as: "Things you must know about me," "Things that are important to me" and, "My likes and dislikes. The registered manager was in the process of introducing a new format to combine both the health action plan and the care passport so that there was just one document to be referred to. The new format enabled information to be recorded in a more person centred way.

The home's policy was to ensure that if a person was admitted to hospital, staff from the home accompanied them for the duration of their stay. This had happened during the year when one person was admitted to hospital. Staff told us that they valued this policy because they knew and felt comforted by the fact that when this person was very ill and dying, they had been able to provide support with all aspects of their personal care in a way that suited them. Staff told us that when the person died, they had been surrounded by relatives and staff who knew them well. We saw correspondence from this person's relatives that clearly expressed gratitude to the staff for the support provided to their relative at a very difficult time.

Where specialists provided guidelines to staff these were available within care plans. For example, the physiotherapist had provided guidelines of exercises that should be carried out for one person. The guidelines stated why the exercises were important and the likely impact of what would happen if they were not carried out. There were photographs of the equipment in use and of the person using the equipment. Staff were able to tell us about the exercises and had a clear understanding of their importance. The detailed guidance and explanations meant that staff had a very clear understanding of the person's needs and how to support them.

Good

Is the service caring?

Our findings

We asked one person who had limited verbal communication if they were happy and if staff were nice to them. They responded, "Yes" to both questions. A relative told us, "The care is second to none and staff keep me informed about everything." Staff gave people the time they needed throughout the day, for example when they accompanied people to the toilet, changed their seated positions, assisted people with their meals and supported them to go out for activities. Staff were relaxed and unrushed and allowed people to move at their own pace.

People were treated with respect and dignity. Staff told us they maintained people's dignity by ensuring their doors and curtains were always closed when personal care was given. They said that if people needed private time in their bedrooms they made sure that this happened. We observed that when one person indicated that they wanted private time, staff discretely encouraged them to go to their room.

Support was provided in line with people's needs. People were supported to keep clean and were appropriately dressed. Hairstyles were individualised. Time was given to ensuring that people looked well. For example, one person had their hair braided and in two canerows with hair accessories. Whilst this person would not have been able to make a verbal choice about how they wanted their hair, they would have walked away if they were not happy with staff doing their hair in this way. At the mealtime staff immediately noted that one person had food on their glasses and they cleaned them. Some people wore aprons at mealtimes to protect their clothes and to maintain their dignity. Whilst most people had not actively chosen to wear aprons but they did not demonstrate any desire to remove them until they had completed their meal. People had specialised cutlery and plates which enabled them to maintain their independence with eating. This showed staff understood the approach needed to provide person centred care.

Staff were observant and attentive to people's needs. The SOFI and general observations showed interactions between staff and people were caring and professional. When staff approached people they did so respectfully and people knew staff were addressing them. People's individual needs were accommodated and their dignity and independence was maintained. Staff supported people to clean their face after their meal where appropriate, and all support was provided discretely. At mealtimes staff sat at tables and supported people who needed assistance, good eye contact was maintained throughout and staff interacted well with people to ensure that the mealtime was a pleasurable experience.

People chose or were given a choice of where they spent their time whilst in the home. For example, some people moved around the home independently and others used vocalisations to prompt staff to move them. Some people when asked were able to indicate either verbally or with gestures that they wanted a change. We noted that people who used wheelchairs were offered regular opportunities to change their position to comfy chairs, bed or time spent on the floor. This meant that in addition to providing a change of scene for the person, staff also ensured that pressure areas were alternated. In addition it meant people were able to have time free from restrictions such as lap belts. Staff were skilled in identifying and picking up on the choices people made.

Staff told us that some people were able to make definite choices about what they wanted to do and with others there was a process of elimination until they found an activity that suited them. We saw this in practice. One person was asked if they wanted to go the sensory room, the staff member stretched out their hand and the person took it and walked with the staff member to the door but then let go of their hand and returned to the lounge. The staff member then asked the person if they wanted a story. The staff member got a book and read to the person. The person appeared to enjoy being read to and they were engaged until the book was finished.

Staff knew people well and were aware that they needed to be observant of people at all times to pre-empt their actions. For example, a jug of juice was momentarily left unattended on a table. One person had waited until the staff member was not looking to grab the jug of juice. However, the staff member was quick to notice this and guided the person away from the jug. The person was offered another drink and the juice was taken to the kitchen.

The sensory room was used throughout our inspection. When activities took place soothing music was played, the bubble light was on, lighting was dimmed and there was a scent burner in the room. This generated a very calming and relaxed environment that people appeared to respond to very well. People's bedrooms were individually decorated and furnished with people's own memorabilia, pictures and collections. For example, one person was a Michael Jackson fan and had several items of memorabilia that they loved and were pleased to show us.

Good

Is the service responsive?

Our findings

A relative told us, "I have no concerns. In the past I have raised minor concerns and they have always been dealt with. (The manager) prefers you to raise them and I feel comfortable as I know they will be sorted." People received support that met their needs and was personalised to their individual choices and preferences.

When people had been on outings outside of the home there were detailed records kept of where they had been and what they had done. Extensive pictorial evidence was in place that showed what people had done and demonstrated that they had enjoyed their activities. Within the home daily records were kept that showed the personal support that had been provided. Record keeping related to activities was less detailed. For example it stated, "(person) enjoyed one to one time in their room with (keyworker)." Records didn't state what they had done and how staff knew the person had enjoyed the activity. This is an area for improvement as despite the limited records, our observations indicated staff responded very well to people's needs and offered them a wide variety of choice and activities.

There was a range of documentation held for each person related to their care needs. This included information about their medical needs, support needs and ability to give consent. The records contained detailed information and guidance about people's routines, and the support they required to meet their individual needs. If someone required specific support to meet a health need such as diabetes or epilepsy there was detailed advice and guidance for staff to follow. People had the equipment needed to support their individual needs such as overhead tracking hoists in bedrooms, hoists for use with the communal areas, individual slings and some had specially adapted wheelchairs. Where people needed support to move around the home, professional guidance had been sought and there were guidelines to ensure this was done in a way that suited them. Advice in care plans encouraged staff to change people's position regularly so that in addition to offering people a change of scene they also ensured pressure areas were altered.

People's weight was regularly monitored and documented in their care plan. A nutritional assessment was completed when people moved into the home and this was reviewed regularly. People's dietary needs and preferences were recorded. Staff ensured that people had enough to eat and drink. Fluid and food charts were only completed where assessed as necessary.

There was information about how people communicated in each care pan. For most people this stated, 'if a person does this, this means and we should'. An example of this could be if a person screams, this might mean they are hungry or thirsty, have been incontinent or are in pain. Staff should by process of elimination check each area and as a last resort offer pain relief. Staff were able to tell us the subtle differences in some people's vocal expressions that indicated their needs. This showed that staff knew people well and knew how to respond to their individual needs.

The complaint's policy was displayed so that people and visitors were clear about how they could raise concerns should they wish to. Although there were no complaints recorded since the last inspection, we

spoke with the registered manager about the issue of confidentiality. They decided that the folder should be stored securely. In this way anyone who chose to raise a complaint could be confident that only those with a right to see the complaint would have access to the records. There were a number of compliment cards which showed that relatives appreciated the care and support provided to people living at Mountain Ash.

People had varied opportunities to participate in activities to meet their individual needs. Two people attend a day centre three days a week and each person had what was known as a day care morning once a week where they were supported on an activity outside of the home. Social evenings were organised periodically and people were supported to go to the theatre or out for a meal or the pub. Most people were supported to go to the library once a month. An aromatherapist provided treatment to one person twice a week. Other people had been given the opportunity to have aromatherapy but had indicated their choice not to take part.

We observed an art session where staff supported people to make painted handprints. The intention was to make a Christmas tree out of the hand prints. Staff gave people clear instructions and encouraged and praised their participation. People were seen to enjoy the activity. One person was supported to join the activity but then choose to walk away and this decision was respected.

Music was played in the lounge. One person demonstrated their enjoyment by humming along to the tune and smiling regularly. Staff read books to people throughout the two days of our inspection. A staff member told us that one person generally didn't like staff reading to them throughout the day; they generally got up and walked away. However they enjoyed this as an activity as part of their bedtime routine and they showed this by actively listening and smiling.

There was a sensory room which provided opportunities for people to take part in activities. Since the last inspection this area had been redecorated and additional lights and equipment had been bought. The room was used regularly throughout our inspection and people were seen to enjoy spending time in this area.

The home has a hydrotherapy pool on site. (Hydrotherapy is a form of exercise carried out in a specially heated pool. The combination of extra heat and the buoyancy of the water help people's muscles to relax and help improve and maintain a person's range of joint movement). We were told that staff supporting people must be swimmers and have completed a lifesaving course. In addition there were always two staff to one person when the pool was in use. Unfortunately the pool was not in use at the time of our inspection due to a part that needed to be repaired. Pool usage over the past feel months had been limited to four swimming sessions monthly from August. We were told that this had been due to equipment failure and they were working to address these matters.

We were told that in response to comments raised by a relative as part of the annual survey, the dining room had been redecorated and made more colourful. A visiting relative had also requested that their relative have a mural on their bedroom wall and this had been done. This showed that the registered manager listened to and where possible acted on the views of people's relatives.

Good

Is the service well-led?

Our findings

From our discussions with staff, the manager and our observations, we found the culture at the home was open, relaxed and inclusive. A staff member told us, "The manager has the service users and home's best interests at heart. They keep everyone up to date and check that service users receive good quality care." A relative told us, "I wouldn't change a thing."

The registered manager told us that they had attended manager's meetings and workshops which had been a good opportunity to meet other managers and to discuss and share ideas and practices. As a result of a recent workshop they had introduced a customer service charter and a staff charter. We were told that the charters were displayed in the foyer of the home they had been discussed at handovers and the next step would be to look at how the home demonstrated the points made in the charter. This showed the registered manager's desire to encourage staff to continually evaluate and improve the care they provided to people.

The provider had strong systems to monitor the management and quality of the home, for example, an internal quality and compliance audit had been carried out in February 2016. This was the organisation's benchmark assessment of how the home was operating against the Regulations and the provider's internal standards. Although there was a lengthy action plan records showed that all actions had been addressed. We were told that the frequency of this assessment would be determined on a risk assessment basis. In addition to this audit the home's operations manager carried out a quarterly audit of the home. Records showed that where actions had been highlighted, they had been signed as having been completed. The audits demonstrated the organisation's commitment to continually evaluate and drive improvements in the way people are supported and how the home is operated.

Through regular internal monitoring the registered manager ensured that a range of audits were carried out to monitor the care and support provided. These included audits in relation to infection control, health and safety and the management of medicines. Where shortfalls had been identified, for example if there was a gap in record keeping, actions had been taken to resolve the matters.

Records were kept of all incidents that had occurred in the home and the home sent notifications to the CQC when appropriate. A notification is information about important events which the provider is required to tell us about.

A range of surveys had been carried out during the year with people, their relatives, staff and visiting professionals. The results and actions taken were sent to everyone involved. One person had asked for lights in the sensory room and this had been done. There were different formats in use to seek people's views and it was acknowledged that for most people the views expressed were those of staff. The manager discussed plans to use photography to show how they know people are happy with the support them receive. In response to comments raised by a relative, the dining room had been redecorated and made more colourful. The response to the staff survey was low. Only seven of the 21 staff responded. As a result of this, the manager had introduced the staff charter, referred to above. The charter placed emphasis on the responsibility of staff to share their views.

In addition to annual surveys staff meetings had been held regularly. Minutes of the meetings were detailed and showed that staff were encouraged to have a say on the running of the home. All discussions were documented and actions reached were clear so that if a staff member had not been at the meeting they would understand the agreed actions and outcomes. A staff member told us, "The manager has an open door policy, if we make suggestions she is open to all our ideas, for example I saw the hand print Christmas tree elsewhere and when I suggested it she gave me money to get supplies needed." Another staff member told us staff often collectively made decisions at staff meetings. For example, they said following discussion at a staff meeting they decided to give one person an additional bath at night time. They said this person, "Enjoys their new routine and is more relaxed and they often choose to stay up later now."

The registered manager had recently introduced a newsletter for relatives of people at Mountain Ash. We were told the intention is to produce quarterly editions of the letter. The newsletter included photos of people enjoying a recent Halloween party and included information about annual holidays, an introduction to new staff members and information about some of the recent activities in and out of the home. The registered manager was pleased with the letter and having completed the first document was keen to develop this area further with additional photos.