Independence Homes Limited

# Independence Homes Limited - 7 Hall Road

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

We undertook an unannounced inspection on 25 January 2016. At our previous inspection on 21 March 2014 the service was meeting the regulations we inspected.

7 Hall Road provides accommodation, care and support to up to seven adults with epilepsy and learning disabilities, some of whom also have physical disabilities. At the time of our inspection seven people were using the service. Each person had additional communication needs, including supporting non-verbal communication.

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

People received a highly individualised and personalised service. Staff were knowledgeable about people's support needs and their preferences as to how they wished to be supported. Support was tailored to meet people's needs and staff had in-depth knowledge of the people they were supporting. People's relatives were extremely positive about the service their family member received and felt they received high quality care that met their needs.

People's health needs were reviewed to ensure they received the support they required. This included regular review of their epilepsy and supporting them with seizure management. People were also supported to access specialist support from a range of therapists, including physiotherapy, occupational therapy, and speech and language therapy. This supported people to maintain their health needs, and ensure they had the equipment and support they required to promote good health. Safe medicines management was in place and people received their medicines as prescribed. The provider's medical team reviewed people's medicines and monitored them to identify any side effects.

A nutritionist worked with staff to ensure people had their dietary requirements met. Staff were aware of people's individual nutritional needs and provided them with the support they required. Staff supported them to develop their eating and drinking skills, and supported people as necessary to ensure their nutritional and hydration needs were met in line with their preferences.

Staff had developed trusting relationships with people. They were aware of people's preferences, wishes and interests. They were aware of people's communication methods and how they expressed themselves. Staff supported people to develop their communication skills and used their knowledge of people's interests to aid communication.

People were supported to make decisions about their care and choices about how they spent their time.

Staff used various methods to support people to make decisions, including supporting them to develop pictorial memory aids and activity plans.

Staff supported people to develop their skills and to progress towards the goals they wanted to achieve. This included supporting them to develop their independence in the community, supporting them to participate in new hobbies and to attend college courses.

Relatives told us staff were highly skilled and trained. Staff felt the training at the service was to a high quality and provided them with the skills they needed to support people. This was particularly in regards to epilepsy and managing people's health needs. Staff's competency and performance was regularly reviewed during supervision and appraisals. Staff were supported and encouraged to develop their skills and implement these within service delivery. A staff recognition scheme was in place to acknowledge staff that had 'gone above and beyond' and a member of staff had recently won the provider's employee of the month award due to the consistently high quality support they provided.

People's relatives and staff felt comfortable speaking with the registered manager. They felt the service was well-led and they felt their views and opinions were listened to. Any concerns raised by people's relatives were dealt with promptly and used to improve service delivery.

The registered manager and the provider's operational team reviewed the quality of service provision. New processes were put in place to address improvements required. The service used relatives of people from a sister service as 'family checkers', as well as management 'walk rounds' and 'service user observation' reviews to help improve the quality of the support provided.

## 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. Safe recruitment procedures were followed to ensure appropriate staff were employed. There was flexibility within the staff team and there were sufficient staff deployed to meet people's needs.

Safe medicines management processes were in place. Staff supported people to have their medicines, in line with their prescription. Any concerns regarding medicines management were discussed with the provider's medical team to ensure any impact on people's health was minimised.

Staff were aware of the risks to people's safety at the service and in the community. Plans were developed to minimise and manage these risks.

Staff followed appropriate procedures to safeguard people from harm. Any concerns that a person was being harmed was discussed with the service's management team and shared with the local authority's safeguarding team.

### Is the service effective?

Good

The service was effective. There was a robust training programme in place to ensure staff had the knowledge and skills to support people. Staff's competency and performance of their key duties was reviewed during supervision and appraisals. Staff were encouraged and supported to practice the skills they learnt.

Staff adhered to the requirements of the Mental Capacity Act 2005. Staff assessed whether people had the capacity to make decisions, and for those that were unable to make decisions about their financial and care needs 'best interests' decisions were made.

People's health needs were met. The provider's medical team regularly reviewed people's health needs, particularly in regards to their epilepsy. Staff liaised with and arranged for additional healthcare professionals to input to people's care as necessary.

The provider's nutritionist worked with staff to develop the service's menu and ensure it met people's dietary requirements.

Staff enabled people to have choice about what they ate, and were aware of their individual preferences. Staff supported people to become more independent with eating and drinking.

## Is the service caring?

Good

The service was caring. People had built trusting relationships with staff. Relatives were overwhelmingly positive about the staff at the service and the relationships they had built with their family member. Staff were aware of people's communication methods and were aware of how people expressed their wishes and emotions. Staff supported people to develop their communication skills.

People were involved in day to day decisions. They used various methods to engage people in decisions and enable them to have choices about how they spent their time.

People were supported to maintain contact with their family and there was regular contact between staff and people's relatives about people's progress. Many of the people using the service had regular overnight stays with their family.

People's privacy was respected and their dignity maintained.

## Is the service responsive?

Good

The service was responsive. People's relatives were positive about the level of care and support people received. They felt high quality care was delivered to support their family member. People received care and support that was tailored to their individual needs. Staff were aware of people's preferences and provided them with support in line with their wishes. This included supporting people in line with cultural and religious wishes.

Staff supported and encouraged people to develop their skills. People were supported to make progress towards identified goals and to develop skills they wanted to achieve. This enabled people to become more independent.

Staff 'champions' were identified to lead on certain aspects of support provided to people, for example supporting people with benefit applications.

People and their relatives were able to feedback about the service. Relatives told us any concerns raised were dealt with quickly and improvements were made in response to their feedback.

## Is the service well-led?

Good

The service was well-led. There was clear management and leadership at the service. People's relatives and staff felt able to have open and transparent conversations with the registered manager. Staff were asked for their feedback about the service during staff meetings and completion of staff surveys. In response to the staff survey, a staff recognition scheme was put in place for staff to vote for their colleagues to become employee of the month and the chance to become employee of the year.

The quality of care delivery was regularly checked. This included obtaining the views of relatives through the provider's family surveys. Formal quality assurance audits were completed monthly as well as senior management 'walk round' visits. Improvements were made and systems were tightened to ensure high quality service delivery.

The registered manager was not aware of all of their CQC registration requirements regarding submission of notifications. We discussed this with them and they addressed it within a timely manner.

# Independence Homes Limited - 7 Hall Road

**Detailed findings**

## Background to this inspection

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

This inspection took place on 25 January 2016 and was unannounced. One inspector undertook this inspection.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications about key events that occur at the service. We also reviewed the information included in the 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.

During the inspection we spoke with six staff, including the registered manager, and briefly to one person. The other people using the service were unable to communicate with us verbally. We undertook general observations throughout the day of the interactions between staff and people using the service, and how people spent their time. We reviewed two people's care records, five staff records and three people's medicines arrangements. We also looked at records relating to the management of the service including, quality checks, incident records and complaints.

After the inspection we spoke with six relatives, and two healthcare professionals involved in the care provided to people.

Good

# Is the service safe?

## Our findings

All the relatives we spoke with felt their family members were kept safe at the service, including at night. They also said staff kept people safe in the community and always ensured people were supported by staff when accessing the community.

Each person was allocated one to one support from staff in line with their risk assessments whilst at the service. Some people required support from two staff in the community, because of the risks to their safety, and additional staff were available to support this. The provider's scheduling team ensured there were sufficient staff on duty to support people's needs. If required the scheduling team organised for bank staff, and on occasions agency staff, to work if permanent staff were not available, for example, due to sickness. We also saw that there was flexibility and support from the provider's other services to ensure staff were available with the appropriate skills to support people living at this service. For example, on the day of our inspection the service's driver was not available, but a driver from another service was available to ensure people still got to their activities and their days were not disrupted because of staffing issues.

Staff were able to pick their shift pattern so that it fitted around their personal commitments, and reduced the need for staff to swap shifts, and ensure consistency in the support provided. Shift start times were staggered to ensure the appropriate number of staff were available to support people at key moments of the day. For example, ensuring enough staff were available to support people to get ready for their activities planned. Two staff were on duty at night. These staff were supported by an 'on call' supervisor in the event that they required additional support or advice at night, for example, if a person became unwell.

The provider's recruitment team followed safe procedures during recruitment of new staff to ensure they were fit and suitable to work within the service. We saw that potential staff were asked to complete applications and attend an interview so their knowledge, skills and values could be assessed. The recruitment team undertook checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK and obtaining references from previous employers and/or character references. We saw that one person, whose recruitment records we viewed, did not have a disclosure and barring service (DBS) check completed. This was in the process of being obtained. Whilst the service was waiting for this information, an 'DBS adult first' check had been obtained to ensure people had not previously been barred from working in similar services. Staff worked with another staff member until their full DBS was completed.

Safe medicines management processes were in place and people's medicines were stored securely. We saw that people received their medicines as prescribed and these was recorded correctly on the medicine administration record (MAR). Protocols were in place to inform staff when people required their 'when required' medicines. Stock checks were undertaken monthly and staff checked medicines delivered to the service were in line with people's prescriptions. We saw that the medicines stock checks did not include the time the checks were undertaken and therefore we were unable to identify whether the stock check took place before or after that days medicines administration. Due to this there was a risk that minor stock discrepancies may occur without being identified. We discussed this with the registered manager and they

told us they would review this with their medical team to get the form updated to include time of stock check and reduce the risk of errors occurring. One person's relative told us the staff ensured people received their medicines as prescribed. They said the staff monitored for any side effects and liaised with people's medical team if they had any concerns regarding people's medicines.

Through the registered manager's quality checks a few medicine errors had been identified. The registered manager told us when these occurred the staff liaised with the provider's epilepsy specialist nurse and the medical team to identify the impact the medicine error had on the person and ensured appropriate action was taken to support the person. Staff who had made a medicine error had their training needs and competency reviewed, and had to be assessed as being able to safely administered medicines before undertaking this duty.

Staff stored people's money for them securely. Records were kept of all financial transactions and there was a daily check of the amount of money stored at the service to ensure it was correct, and people's money was kept safe. We checked three people's finances and saw the balance was as expected.

Risks to people's safety were assessed and identified. Staff developed management plans to minimise the risks to people's safety and these were incorporated into people's care plans. Staff also supported people to self-manage the risks to their safety. For example, not going near the cooker when in use. Staff supported people to manage risks in the community. For example, people received support from either one or two staff when in the community depending on the risks to their safety, their level of road awareness and the risk of them wandering from the group. People had the equipment they needed to manage the risks to their safety. For example, some people used a wheelchair in the community because of their mobility needs and increased risk of falls. Other people wore protective headwear because they were at risks of uncontrollable seizures and this reduced the risk of a head injury.

The service used technology to assist with risk management. For example, the service used technology that monitored if people were having a seizure during the night, whether they had left their bed and any increase in moisture. If the technology identified any change an alarm was raised and staff supported the person as required.

Staff followed the provider's procedures if an incident occurred at the service. All incidents were reported to and reviewed by the registered manager to ensure appropriate action was taken to support the person and to identify how the staff could further support the person to reduce the risk of the incident recurring. All incidents were shared with the provider's management team who reviewed them to identify any patterns. Any patterns identified were discussed with the registered manager and the provider's medical team to assess whether it indicated a person's support or health needs had changed.

Staff were aware of their responsibilities to safeguard people from harm. Staff were knowledgeable of the reporting procedures to follow if they had concerns a person was being harmed. The management team liaised with the local authority's team if they had concerns a person was being harmed, and undertook investigations in line with advice given.

Good

# Is the service effective?

## Our findings

Staff had the knowledge and skills to meet people's needs. All the relatives we spoke with spoke highly of the staff. They felt they had received the training they required to support their family member, particularly specialist training to support the person with their epilepsy. One person's relative told us they felt their family member would be in "extreme danger" if they were removed from the service because they would not have the support from staff who had received "intense training." A healthcare professional said the staff "are without fail, always helpful, attentive and focused" on their duties and the support provided to people.

The registered manager ensured staff stayed up to date with good practice guidance through the completion of training courses. Staff told us they felt the training gave them the skills and knowledge they required to undertake their roles. We saw that staff had completed the training the provider deemed mandatory for their role. This included, health and safety, fire safety, infection control, medicines administration, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, safeguarding adults, first aid, and moving and handling. All staff were also required to complete training on epilepsy. Some staff had completed additional training relevant to their role, for example 'water rescue'. This ensured staff were trained to be able to support a person when swimming if they experienced a seizure. The service's driver and cleaner also received the provider's mandatory epilepsy training so they were able to support the care staff if a person was having a seizure.

There were some concerns raised from staff that the use of bank and agency staff meant there was some inconsistency in staffing. They told us that bank and agency staff were required to complete the same training as permanent staff so they had the knowledge and skills to support people, however, because people were not familiar with them this impacted on the interactions between staff and people. We spoke to the registered manager about this and they said that the provider was increasing their rotation of staff at different services, so that all staff became familiar with people using the service and their needs. This would enable flexibility in the allocation of staffing to cover staff shortages but also ensure people were comfortable and relaxed with the staff supporting them.

Staff received supervision every two months. They told us they were able to request additional supervision if they felt it was necessary or had any concerns they wanted to discuss. Through the supervision sessions and during annual appraisals staff, with their supervisor, reviewed their performance in line with the competencies attached to their role. Information and support was provided to staff about how to improve their performance and what was expected from them. Staff were also encouraged through supervision to use the skills they achieved through the completion of training courses. For example, we saw a team supervisor was encouraged to use the skills they achieved during their coaching and management training. They had also attended training to be a care certificate assessor, and were supporting new staff who were completing their care certificate as part of their induction. The care certificate is a nationally recognised tool to provide staff with the basic knowledge and skills to undertake their role.

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. Staff were aware of their roles and responsibilities under the Act. Staff worked with people's relatives to inform them about the Act and the formal processes they should have in place to promote people's best interests, such as if they were managing people's money on their behalf. We saw one example where a person's relative was an appointed deputy and had been formally authorised to make decisions about the person's financial affairs and manage their money as the person did not have the capacity to manage their own finances.

Staff supported people to make decisions but if they were unable to make a decision because of a lack of capacity they liaised with their relatives and relevant healthcare professionals to make those decisions for them. However, these assessments and discussions were not always documented in full in people's care records. For example, staff had assessed that due to one person's seizures at night that they required bed rails to keep them safe and stop them from falling out of bed. The staff were unsure how much the person could weigh up the risks and benefits of having bed rails in place. They had discussed this with the person's family and the staff had made the decision that having bed rails was in the person's best interests. However, this was not robustly documented in the person's care records. We spoke to the registered manager about this who said they would update the required documentation. The registered manager had also arranged for this restriction to be reviewed as part of the person's DoLS authorisation assessment.

Staff were aware of their responsibilities to keep people safe. The registered manager had assessed that in order to keep people safe they felt they needed to deprive people of their liberty. They had made applications for authorisation to deprive people of their liberty and two authorisations had been granted by the local authority. Staff adhered to the conditions of the DoLS authorisations and these fed into the care planning process. The registered manager was waiting to hear from the local authority about the other applications. In the meantime people were supported in line with their risk assessments.

All the relatives we spoke with felt their family member's health needs were being met by the staff and the healthcare professionals that came to the service. The provider had their own internal medical team which consisted of the medical director and specialist epilepsy nurses. The provider also had close links with community neurologists and contracts with other health professionals including nutritionists, speech and language therapist, physiotherapists and occupational therapist. These staff were available to review people's medical needs and provide support to people and staff as required. A monthly medical meeting was held to review each person's medical needs and ensure they were receiving the support they required with their health needs. These focussed on people's needs in regards to their epilepsy and whether there had been any changes in the frequency, duration, time of seizures and any other health concerns.

Staff were provided with training and information about people's individual needs in regards to their health and how this related to their epilepsy management. For example, some people at the service had a condition which meant it was harder for them to get up after a seizure. Staff had discussions about what this would feel like for the person and how they were to be supported to get up in their own time and without causing additional pain to the person. In other cases staff supported people and involved their relatives in

understanding and using technology to help manage the frequency and severity of people's seizures. For example, staff told us they had worked with one person in regards to using Vagus nerve stimulation (VNS) therapy. This involves a device sending mild electric stimulations to the brain to calm down the irregular electrical brain activity that leads to seizures. Staff also supported relatives to understand this technology which was used when the person made home visits. The registered manager told us the use of a VNS for this person had helped shorten their seizures and support with their recovery.

The registered manager also liaised with external healthcare professionals to ensure people's health needs were met. This included having regular input from a physiotherapist and we saw on the day of our inspection two people were being helped by the physiotherapists to improve their mobility. The physiotherapist was working with staff to support people to strengthen their muscles and enable them to be more independent with their mobility. For example, one person required the use of a wheelchair in the community for long distances. The staff had supported the person to take regular short walks to build their muscle strength and were working with the physiotherapist to gradually increase the amount of exercise the person undertook. The physiotherapist was visiting on the day of our inspection and we observed staff supporting people with their exercises.

Another person received daily input from the community nursing team to ensure they received the medicines they required through a daily injection. And occupational therapists were involved in people's care to review their daily living skills and ensure they had the support they required from assistive technology and mobility aids to meet their needs. For example, we saw in one person's care records that they required the use of a bath seat to be able to have a bath. A healthcare professional we spoke with felt the joint working and co-ordination of care provided by staff enabled them "to provide an excellent service that meets everyone's needs."

Speech and language therapists (SaLT) and dieticians were involved in people's care if they had specialist nutritional needs. For example, if people had dysphagia (difficulty in swallowing) and were at risk of choking. There was detailed information in people's care records about how to support them at risk of choking and staff supported people to have soft foods.

We were informed that the provider's nutritionist had worked with staff to develop the service's menu so that it incorporated people's dietary requirements and provided a healthy, balanced diet. This included ensuring people who needed either a high or low calorie diet received this. And for people who were known to experience regular constipation due to the side effects of their medicines that they were provided with the appropriate food to naturally address this without the need to take further medicines.

Meals were freshly prepared and cooked by the staff at the service. People were supported to eat at times that suited them and were able to choose what they wanted to eat. Staff provided people with alternatives if they did not want what was planned on the menu for that day's meals. Some people were able to access the kitchen and point to what they wanted to eat and staff supported them to prepare and cook it. Staff were aware of people's hydration requirements and monitored people's fluid intake when required. Staff were aware of people's preferences in regards to how they preferred to drink and supported them with appropriate adaptive cutlery. Staff were supporting people with their independence in regards to eating and drinking. For example, one person had been successfully supported to eat with minimal assistance. If staff cut up the person's food they were able to use a spoon to eat independently.

Good

# Is the service caring?

## Our findings

All the relatives we spoke with were positive about the way staff related to and engaged with people. They felt staff were approachable, friendly and caring. They told us the staff had built strong relationships with their family member. They knew the person well and how they expressed themselves. One person's relative said, "There's excellent staff there." Another relative told us, the staff have the "patience of a saint." All the relatives said their family member was happy at the service and enjoyed living there. Some people had been living at the service and with the same people for a number of years and they had built friendships with each other. Each relative told us the person was happy to go back to the service after a visit to their family home and one person's relative told us the person looked forward to going back to the service after a few days away.

From the brief discussion we had with one person using the service they told us they were happy living there and they liked the staff. We observed staff speaking with people politely and in a friendly manner. Staff supported people at a pace dictated by the person. In the afternoon people at the service were engaging in activities they enjoyed. For example, one person was playing with their puzzles, another person was drawing and a third person was playing with their musical instrument. Each person was supported by an allocated member of staff.

Staff were aware of people's communication methods so they could better communicate with people and offer them information in way they could understand and respond to. Staff told us most people were able to understand verbal communication and what was being asked, but they were not all able to verbally communicate in depth with staff. From spending time with people staff had identified how people communicated. This included understanding what people's noises, single or short word phrases meant, and what gestures and/or signs they used. Staff were also aware of how people's communication changed when expressing their emotions. For example, one person made a higher pitched noise if they were becoming frustrated.

Staff liaised with the speech and language therapist about people's communication needs to better support people in this respect. We saw that people had communication guidelines in their care records to ensure staff were able to understand how people communicated through the use of gestures, signs, touch cues and objects of reference. For example, staff used touch cues with one person by touching their ear if they wanted them to listen or touching their face to the side of their eyes if they wanted the person to look at something. Staff also used people's interests to aid communication. For example, one person liked puzzles. The staff took the person's puzzles and put it in the bathroom to indicate to the person it was time for them to have a bath. Staff also used the person's puzzles to support them to take their medicines. The person would not take their medicines if given to them directly, so staff put the medicines on the puzzle the person was playing with and then the person was happy to take their medicines.

The staff used individual ways to communicate with people according to their needs. For example, one person was better able to retain information and follow sequences using pictures rather than verbally being told. The staff supported the person to use a pictorial calendar in their room so they were able to remember

what day it was. They also used a pictorial activity programme so each day staff supported them to put up the pictures of activities they wanted to do that day.

Some staff had learnt Makaton. This is programme that uses signs and symbols to support verbal communication. Where possible staff supported people to learn Makaton to try and improve their communication skills. We saw an example during the inspection where after agreeing with the person's relatives, staff at the service had started to work with the person to learn Makaton. Staff told us about the progress the person was making and how they continued to embed this means of communication when interacting with the person.

People were involved in decisions about their day to day support and how they spent their time. All the relatives we spoke with told us the staff knew their family members well and knew how they expressed themselves to make their wishes known. One person's relative told us staff supported people in line with their decisions and "they evaluate what's in their best interests." They told us their family member was able to say 'no' and if the person did not want to participate in an activity the staff respected their decision.

Staff ensured they used appropriate language and communicated with people at a pace suitable to the individual and in line with their communication guidelines to fully enable them to make decisions about the support they received. For example, some people were unable to process a lot of information and having too many options made decision making harder. Therefore staff were conscious to use short sentences and only offer two or three options to aid decision making.

People's relatives told us they felt well informed and involved in people's care. Two people's relatives told us they had daily contact with the staff. They said staff involved them in people's care and one relative said that "nothing was done without talking with me."

Staff supported people to stay in contact with their family. One person was returning from a weekend visit to their parents on the day of our inspection. Staff told us most people visited their relatives and had regular overnight stays at their family home. We also saw staff supporting people to keep pictures of their family and friends in their bedrooms to provide a homely environment for them and for them to remember their relatives and friends.

Staff were respectful of people's dignity and privacy. We saw that personal care was always delivered in the privacy of people's bedrooms or the bathrooms. All people presented well and were supported to have a good standard of personal care. Where required, staff were quick to support people with their continence needs to ensure their dignity was maintained.

Good

# Is the service responsive?

## Our findings

All the relatives we spoke with were very happy with the level of care and support their family members received. One relative said, "On a scale of one to ten, I'd give them an 11." They also told us the care their family member received "was as good as you're going to get." Another relative told us, "I'm very satisfied with the level of care. I wouldn't want [the person] to be anywhere else."

Staff were knowledgeable about the people they were supporting and their health, care and support needs. They were able to describe what support people required and how they wished that support to be provided. Staff were conscious to enable people to do as much as they could for themselves and supported them to be as independent as possible with key tasks, including maintaining their personal care. People's care records contained detailed information about people's support needs. We saw daily support plans were developed using the information from people's care records. This included information about people's routines and the order they liked to undertake tasks. For example, one person needed support with brushing their teeth. Staff were instructed to brush the person's teeth in the same order so the person was aware of what to expect. It also included information about the level of support people required. For example, one person was able to maintain their own personal care with prompting from staff, but they required assistance from staff to wash their hair.

People were supported in line with their preferences, for example, one person did not like cold surfaces. Therefore staff put a warm flannel on their bath seat before asking them to sit down. People's care records contained information about how their support needs impacted on their epilepsy. For example, certain aspects of personal care were a known trigger to one person's seizures and therefore staff needed to make sure they supported the person appropriately to reduce the risk of seizure.

People's care plans included information about behaviour needs and how people were to be supported if they became frustrated or distressed. For example, one person could become concerned with a certain task. Staff gave the person time to undertake the task at their own pace but learnt when to distract them with another task before the person became anxious and which could lead to them challenging staff with their behaviour.

People had allocated key workers. Key workers are a member of staff dedicated to lead and review people's support and care needs. They met regularly with people to review their support needs and their progress towards identified goals. Each person had a weekly programme of activities they participated in and these linked to the goals that people wanted to achieve. For example, one person wanted to learn to swim and there was scheduled time for the person to go swimming to help them achieve this goal.

Staff were supporting people to grow in confidence and to try new things. One person wanted to go on holiday with their parents, but were unsure about using public transport and going on an aeroplane made them anxious. Staff had worked with the person to become more familiar with public transport and become more confident using it. At the time of our inspection the person was successfully using trains and buses with support from staff.

On the day of our inspection people had busy days engaging in meaningful activities. This included both activities that were beneficial for their health including physiotherapy and hydro therapy, as well as leisure activities including music therapy, art sessions, going to a local pub for lunch and a clubbing activity in the evening. One person's relative told us, "[The person's] been doing a lot more activities [since moving to Hall Road]." Another person's relative said, "[The person] loves art therapy." The art therapist had supported the person to work on an art project as a present for their parent's birthday. The relative appreciated the support the person was given to be part of family life.

Some people at the service had started to engage with a local college. They were working on a programme to help them to integrate into the community, and build links with community groups with the long term goal of supporting them to participate in work experience and volunteering opportunities.

The staff were aware of people's cultural heritage and their religious beliefs. They were respectful of people's culture and adapted the support provided to meet people's preferences. For example, in regards to supporting people with their continence needs.

There were 'in house staff champions'. These staff members led on particular areas of service delivery to support people, their relatives and to train the staff at the service if they needed additional knowledge or assistance. For example, one staff member had become a benefits 'champion'. They worked with people and their relatives to inform them about what benefits and financial support they were entitled to and helped them to apply to access this.

The complaints process was displayed in the communal area at the service. All complaints were responded to and investigated. All complaints received were reviewed by the provider's management team to ensure appropriate action was taken to address the concerns raised. All the relatives we spoke with told us they felt able to raise any concerns they had with the registered manager. They felt all comments were taken seriously, their concerns were listened to and action was taken to make improvements. Relatives who had previously raised concerns felt satisfied that appropriate action was taken to resolve their concerns. One person's relative said, "If there's issues we resolve them." Another relative told us, "I have no complaints what so ever."

Good

# Is the service well-led?

## Our findings

Feedback from relatives and healthcare professionals showed that the registered manager was approachable and listened to their views. One person's relative said the registered manager was "excellent", "very, very good." Another person's relative told us they believed the current registered manager was the "strongest" manager that has been in post at the service. A healthcare professional said the registered manager was "a welcoming person" and there was good communication with them. They also said, "[The registered manager] tries very hard to do her best [for people]." Another healthcare professional told us, "[The registered manager] has always been both available and approachable at all times." They added "[The registered manager] provides me with the required information in a timely manner and keeps in touch with me frequently to update me regarding [people's] health."

One staff member said, "[The registered manager] always puts people's needs first." They also told us they felt well supported by their manager. They felt comfortable speaking with them, and were "happy to ask for help and happy to speak up." Another staff member said, "[The registered manager is lovely. She's the best." They told us whenever they needed to discuss anything her door was always open.

There was a clear management and leadership structure at the service. This included three team supervisors who led on the day to day shift management of the service, and allocation of tasks to ensure people's daily needs were met. The registered manager oversaw the management of the service and ensured staff followed the service's systems, processes and dealt with any concerns raised. The staff we spoke with were aware of their roles and responsibilities, and felt comfortable speaking to any member of the management team if they had any concerns, questions or worries. We observed staff freely approaching the registered manager and the registered manager making time to speak with them.

There were regular staff meetings and minutes from the meetings were available for staff to read if they were unable to attend the meetings. We saw the minutes from the previous meetings and there were opportunities for staff to add their own agenda items to be discussed at the meeting. There was also a staff survey completed by the provider. The registered manager told us that any service level themes from the staff survey were discussed with them so an action plan could be incorporated. At the time of our inspection the findings from the 2015 survey were being analysed. The findings from the 2014 survey showed the provider wanted to increase staff feedback mechanisms and improve staff recognition within the company.

At the time of our inspection a staff recognition scheme was in place to acknowledge staff who had 'gone above and beyond' across all the provider's services and also within the staff team at Hall Road. One staff member at Hall Road had recently won the employee of the month award due to consistently positive feedback from people's relatives and their colleagues about the quality of care and support they provided. We observed that there was a box in the staff's office for staff to include examples of where staff members had 'gone above and beyond' their duties and these were discussed and acknowledged during staff meetings.

The provider encouraged feedback from people's families and used this to improve the quality of service

provision. A 'family checker' initiative was in place. This initiative invited relatives of people who used the provider's other services to visit and comment on the interactions they observed. This also included reviewing the activities on offer and speaking with staff. The last 'family checker' visit took place in December 2014 and they rated the majority of aspects of service delivery they viewed as 'excellent'.

The quality of service delivery was reviewed by the registered manager, as well as by the provider's operations department. Processes were in place internally for staff to undertake daily checks of people's medicines management and the management of people's finances. Managers from the provider's other services came to undertake 'service user observations.' Through this process the manager reviewed the interactions between people and staff, reviewed the environment and how people spent their time. Any areas requiring improvement were discussed with the registered manager so appropriate action could be taken to address any concerns.

Formal monthly quality assurance checks were undertaken based on the Care Quality Commission's inspection methodology and the Health and Social Care Act 2014 regulations. The operations manager undertook 'walk round' spot checks. These were unannounced and included checking the quality of service delivery during the day and at night. If improvements were identified as being required these were discussed with the registered manager and an action plan was produced.

We looked at the latest monthly quality assurance checks and noted that the main concern identified was the occurrence of medicine errors. In response to this the registered manager had amended the timings of the daily medicine checks to ensure these were undertaken within a certain time frame after medicines should have been administered, so that any errors could be identified early and the person could still receive their medicines safely.

The registered manager ensured all staff were fulfilling their roles and responsibilities to a high standard so people received their care and support appropriately and safely. They discussed and dealt with any performance concerns regarding individual staff members, and if required disciplinary procedures were followed.

The registered manager was unsure about their responsibilities in regards to the submission of statutory notifications. At the time of the inspection they were not aware that they were legally required to submit notifications on the outcome of applications to deprive a person of their liberty. We informed the registered manager of this requirement and they submitted the required notifications on the day of the inspection. They also shared this learning with the registered managers for the provider's other services.