Dolphin Homes (Southern) Limited

Hill Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 February (unannounced) and 1 March 2018 (announced).

Hill Lodge is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hill Lodge accommodates 18 people with a learning disability and / or physical disability in five adapted buildings. There were 16 people living at the home when we inspected. The care service has been developed and designed in line with the values that underpin the Registering the Right Support CQC policy and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in place. 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.

At the last inspection, in 2016 the service was rated Good. At this inspection we found the service remained Good.

In 2017 there was a change in registered manager and several safeguarding concerns were made. This inspection was carried out after the safeguardings had been closed and an action plan was in place to improve the service.

People were safeguarded from avoidable harm. Staff adhered to safeguarding adults procedures and reported any concerns to their manager and the local authority.

People told us they felt safe. Risks were assessed to minimise them and staff were aware of people's individual risks. People received their medicines safely and they had their nutritional and health needs met. Emergency systems had been put in place to keep people, visitors and staff safe.

Staffing levels ensured that people's care and support needs were safely met and safe recruitment processes were in place. Medicines were managed safely.

Systems were in place to ensure the premises were kept clean and hygienic so that people were protected by the prevention and control of infection. There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service

People's needs and choices were assessed and their care provided in line with up to date guidance and best

practice. They received care from staff that had received training and support to carry out their roles. People were assisted to prepare their own meals and make healthy choices to maintain their health and well-being. Staff supported people to attend appointments with healthcare professionals. The service worked with other organisations to ensure that people received coordinated and person-centred care and support.

People's diverse needs were met by the adaptation, design and decoration of premises and they were involved in decisions about their environment. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and they gained people's consent before providing personal care.

Staff were caring and compassionate and people were relaxed in staff company. People were treated with dignity and respect and staff ensured their privacy was maintained. People were encouraged to make decisions about how their care was provided and staff had a good understanding of people's needs and preferences.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred. Care plans were person centred and reflected how people's needs were to be met. Records showed that people and their relatives were involved in the assessment process and the on-going reviews of their care. They were supported to take part in activities which they wanted to do, within the service and the local community. There was a complaints procedure in place to enable people to raise complaints about the service.

The service had an open culture which encouraged communication and learning. People, relatives and staff were encouraged to provide feedback about the service and it was used to ensure continuous improvement. Staff were motivated to perform their roles and worked to empower people to be as independent as possible.

The registered manager adhered to the requirements of their Care Quality Commission registration, including submitting notifications about key events that occurred. A programme of audits and checks were in place to monitor the quality of the service and improvements were made where required. The service had changed, according to staff for the better and now these changes needed to be embedded into every day practice.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Hill Lodge

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 27 February unannounced and 1 March 2018 announced. The inspection was undertaken by two inspectors and two experts 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. The experts by experience backgrounds and expertise were in caring for people with learning disabilities and autism.

Prior to the inspection we reviewed the information we held about the service, including the history of the safeguarding concerns in 2017 and statutory notifications submitted about key events that occurred 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 13 staff, including the registered manager. We spoke with ten people and observed interactions between staff and people using the service. We reviewed four people's care records plus five staff records such as supervisions, recruitment and training. We reviewed medicines management arrangements and records relating to the management of the service, including audits, policies and procedures.

Good

Is the service safe?

Our findings

People told us through words, pictures and signs that they felt safe at the home. One person told us "It's a fun and exciting place to live, we are all one big family." Staff told us "We have training in how to keep people safe, especially in the kitchen. One person doesn't like the kitchen and they can be a risk with hot water."

The staff told us they had undertaken adult safeguarding training. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. Staff knew how to raise whistleblowing concerns and one commented, "If you suspect someone at work is doing something wrong, you must report it." We saw that incidents had been reported to the relevant authorities as required.

Risk assessments were in place to reduce the likelihood of injury or harm to people. These included accessing the community, working with tools, working in the kitchen and using public transport. They were completed in a way that allowed people as much freedom as possible, and promoted people's independence. In all instances, these had been reviewed on a monthly basis to make sure they remained up to date and reflected changes to people's circumstances.

Staff understood how to prevent and manage behaviours that could challenge others living with them. They told us, and records confirmed they regularly completed training in Autism Awareness and Positive Behaviour Support (PBS). This is training on how to manage behaviours that could challenge themselves and other people. This meant that staff knowledge was up to date and followed the most recent best practice guidance. This helped to reduce the number of incidents of behaviours that challenged themselves and other people and helped to make people feel safe.

One member of staff said "We are taught PBS which is touch support and assertive command, it's the first thing you do. I've never had to use restraint. I usually redirect them to their room." A second member of staff showed us the "protective stance" they had learnt in PBS training. They said "When [name] is agitated they will grab your hair which really hurts. The other staff will go behind them to get them to release." They showed us how this was done. Staff told us that "[Name] is strong but they respond to a firm command like 'stop'". The members of staff all demonstrated a good level of skill when dealing with challenging behaviours such as when a person becomes distressed. They explained that 'We talk to the person in a calm way, bringing ourselves down to their level and making eye contact; we treat them like any other person."

Staff gave us another example of helping people manage their behaviours, "[Name] calms their self down by going for a walk." We observed this when the person banged the table and then walked around the lounge. One member of staff informed us the person was agitated and another asked them to stop and asked them if they wanted to go for a walk. They went to the person's room and came back out with coats on and left the property. Staff said they did not know why he was banging on the table but felt it could have been our presence.

We noted there were detailed manual handling assessments in all the support plans we looked at. These described in detail how people should be safely helped to move and reposition.

The premises were purpose built and as such did not present significant difficulties in evacuating people in the event of an emergency. There were Personal Emergency Evacuation Plans (PEEP) in support plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood. The building was appropriately maintained. There were certificates to confirm the premises complied with gas and electrical safety standards. Appropriate measures were in place to safeguard people from the risk of fire. Staff had been trained in fire safety awareness and first aid to be able to respond appropriately.

There were enough staff to support people safely. Staff said they felt there were sufficient staff to meet people's needs and the registered manager commented, "We use certain agency staff to ensure consistency with supporting care needs." We observed sufficient numbers of staff on shift to support people and rotas showed that staffing was consistent. Support was provided 24 hours a day. Additional support was available on call if staff needed advice or in the event of an emergency.

Safe recruitment practices were followed; several new staff had been recruited since the home's last inspection in 2016. Recruitment checks included obtaining references from previous employers, checking people's eligibility to work in the UK and undertaking criminal record checks. These checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults. One person told us they had been involved in recent recruitment and they had thought of their own questions. They told us they had asked about fire safety; they shared with us their question and the answer they would expect prospective staff to give in response.

We looked at the Medicines Administration Records (MAR) for 15 people living at the home. We saw that people had a 'medication profile record' which listed their medicines, side effects and the times they were to be given. Records showed that people had regular reviews of their medicines to ensure they remained appropriate to meet their needs. Staff told us and records confirmed they were trained to administer medicines safely. We asked one person if they took medicine to which they said "yes". We asked if they looked after their medication to which they replied "Yes and staff helped." We observed people were given the choice as to where they would like to take their medication. Questions were asked such as, "Would you like you to take your medication here or shall we go to your room".

We found some gaps in people's MAR's. The home had a medicines check system which the manager explained was to ensure that people had received their medicines. We showed the registered manager that some of these records and those the night staff were requested to keep had not been completed as they the manager had thought. The registered manager assured us that this would be added to their action plan and the action taken would be to raise this at team meetings and issue urgent reminders to all staff.

A number of people living at the home lived with epilepsy. Their MARs contained detailed information and guidance about the use of medication, and action to be taken in the event of a seizure. This documentation was also in support plans.

One person had a percutaneous endoscopic gastrostomy (PEG) in place. PEGs involve placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be delivered when taking in food and drink orally was limited or no longer possible. Staff were knowledgeable about the management of these; relevant staff had been trained in this area.

People were protected by the prevention and control of infection. The premises were kept clean by staff.

Regular monthly audits were completed that included hand washing, infection control procedures, COSHH, legionella and water checks. We saw that where areas required attention, remedial actions were taken and records confirmed this. Staff had completed training in infection control and food hygiene. We found some areas where staff had not taken precautions. We spoke with the registered manager about the storage of mops and buckets and how staff had washed clothes and bedding which had bodily fluids on them. The manager told us they would remind staff of the correct procedures. There was adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves.

Staff understood their responsibilities to raise concerns in relation to health and safety and near misses. This information was raised with the provider who took an overall view of all their services. Where needed action plans were raised and then monitored. Staff told us that if there was an incident they would "call 999". They went on to say "The risks of incidents are high mainly because of behaviours". They explained about completing a body chart to show injuries. This was shown to us. Another member of staff had noticed a bleeding cut on one person's toe and we saw the member of staff had a body chart in front of them and they circled the affected toe, wrote a brief explanation, dated and signed it. They confirmed "It goes to head office to be checked and filed."

Good

Is the service effective?

Our findings

People's care was effectively assessed to identify the support they required. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their individual needs.

Staff told us how they had discussed with other professionals ways to assist someone with their anxieties. We were shown a laminated sheet entitled "Sensory Diet" (an activity or task that required the person to be calm yet alert, focussed and settled). It explained a number of "sensory meals" being provided throughout the day at regular intervals. For example weights; the staff told us "The community nurse has suggested them for [Name] to relieve their anxiety." The staff said [name] liked carrying things in their hands and this can act as a therapy for them." Other 'meals' included sensory toiletries, a back scrubber, and vibration – such as a cushion they could sit on. One member of staff said, "[Name] used to sit with their face leaning on the washing machine when it was on and they seemed to like the vibrations. The cushion really seems to calm [Name] down."

Staff had the knowledge and skills to carry out their roles and responsibilities. Within the staff files we saw that staff had been provided with induction and on-going training. We saw the Skills for Life Care Certificate training was in place for all new staff. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. We asked staff about the support they received. One member of staff said, "I have had probationary meetings and then I will have supervision." Another member of staff said they had completed training in epilepsy and autism. We asked them for an example of what they had learnt from autism training. They said "Intensive interaction - when they have behaviours, you try and copy what they do to get into their world. You replicate them and how they communicate."

A relative told us, "The staff are very good. This is the best it's been for a while." Staff were provided with relevant support and training to enable them to carry out their roles appropriately. One staff member said, "My induction was good. I worked alongside an experienced staff member until I felt confident to work alone." A second member of staff commented, "The training gives us everything we need."

The staff we spoke with were knowledgeable about people's individual dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves.

The support plans we looked at reflected the high level of staff awareness of the importance of good nutrition and hydration. For example, one member of staff explained about the involvement from the speech and language therapist (SALT) team for one person. They had suggested a special cup (that was shown to us and we observed the person using it). This helped prevent the person from swallowing too much in one gulp which caused them to cough. Food was cut into small pieces and sauces added to aid swallowing as the person also eats quickly.

Care plans, showed that people were able to access a wide variety of core and specialist external services.

For example, referrals had been made on behalf of people to agencies such as hospital consultants, dieticians and the Community Team for People with Learning Disabilities.

Each person had a health action plan which was regularly updated outlining their healthcare support needs. We saw in people's records they had attended their annual health check with their GP and also had access to other primary care services. Staff supported people to their health appointments, including any specialist appointments they required. We saw that input from other services and professionals was documented clearly in people's files, as well as any health and medical information.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff understood their roles in assessing people's capacity to make decisions and people told us they were always asked about consent to care and treatment.

The support plans included assessments regarding people's ability to consent to their care and treatment. People had up to date mental capacity assessments in place and these were carried out in the process of care planning and review. Where a person did not possess mental capacity, their records contained evidence of best interests meetings with relevant parties and referrals for DoLS authorisation when necessary. These were 'decision specific' and outlined clearly why authorisation was being sought.

People's diverse needs were met by the adaptation, design and decoration of premises. For example, we saw that where needed people had their equipment which had been adapted for them and this was monitored in case there were any changes. People could have time on their own in their room or in a sensory room. This allowed them to have their own space but ensured they could socialise with others if the wished. One person told us, they had decided on the colours for their room. The service was reasonably well maintained and decorated. There was a lounge and kitchen for people to use in each house as and when they wished. We observed people navigating around the home independently where possible. Each person's bedroom was personalised and provided en-suite bathroom facilities. There were resources and sensory stimulation for people to use at their leisure.

Good

Is the service caring?

Our findings

Staff were knowledgeable about the people they supported and what was important to them, such as family members and any hobbies or interests they had. Staff spoke with us about people in a dignified and professional manner throughout the course of our visit. They were able to explain to us about the care and support people needed. Staff actively involved people in making decisions and asked them what they would like. Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People were able to comment about their care and the support they received through regular reviews, informal discussions and surveys sent out by the provider.

We found that people using the service had varying degrees of ability. The staff approach and ethos of the service was focused on people's strengths, gifts, and talents. People were treated as individuals and had outcome focused care plans which they were involved in completing and reviewing on a monthly basis. One person showed us their care plan and we could see where they had contributed to the support they wanted and needed. The care plans included information about people's areas of strength, special interests and how they made choices. We saw that people's choices were respected. We also saw that people could have access to an advocate if needed when making care and support decisions.

We observed care and support given to people throughout the two days. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff and no incidents of infantilising or discourteous staff actions. For example one person needed to have regular pressure relieving time on their bed. They became quite upset at being in their room and we observed staff sitting with them reading to them. We heard the person change from being upset to laughing and giggling at the manner of the member of staff reading to them.

We observed [Name] go into their kitchen and make their own cup of tea. They then wiped the table in the lounge. They showed us the menu in the kitchen and we asked what they were having today. They pointed to Tuesday, we asked them if they liked "Chicken Kiev's and chips" they responded with excitement and said "Yes". Another person, although a risk in the kitchen, was supported to make their own drink. The staff member repeated instructions until [name] carried them out. We observed this throughout the day with this person being able to do most things by them self. When asked if they wanted a biscuit they gave a very clear noise that indicated 'yes' and a Makaton sign where they put their hand to their mouth like a thank you or please. The staff member put the packets in front of them to choose what they wanted.

Others said I choose what I like to do in the morning, today I'm going out to town on my own to have a look at the shops". "I'm going to the pub today, I'm really looking forward it, and it's one of my favourite things to do". People were supported to be independent.

Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people really well; for example, staff knew people's food preferences without referring to

documentation. Those at risk were monitored closely but discreetly where necessary; for example, those presenting with choking risks.

We observed a member of staff communicating with one person through Makaton (a form of sign language), with question and answers. The person communicated they were hungry. The member of staff responded with 'biscuits' by doing a Makaton sign and saying the word, which the person responded to with 'yes, please' through Makaton sign. The member of staff put the plate of biscuits on the table but the person indicated they wanted them in their chair. They were then moved to where the person wanted to eat them.

Staff told us about people's individual likes and said "Some like breakfast before they have a bath or a shower and it's their choice, so we ask them so we know what they want to do that day." One member of staff said "[name] likes going out for a walk every day and this makes them happy." We asked the person when they came out of their room what they liked doing to which they replied "walk." We asked if they had been out for a walk that day to which they said "yes". We observed one person in their room with sensory lights on, curtains pulled, headphones on listening to music. A member of staff came out of their room with a guitar the person told us the staff member had been playing to them. The person sang throughout our conversation. The member of staff said "I'm a big believer in music therapy." They had been observed playing the guitar earlier in the day.

In each of the bungalows there were different colours on the walls. In Beech, one person had two colours on their wall as their bedroom was getting painted in the next few weeks. They showed us which colour they preferred by touching it. The staff member said they were getting the paint together later that week. In one bungalow everyone had chosen their preferred colour by putting their hand prints on the wall in the lounge. One person who showed us their bedroom said they liked "green and music" and showed us their CD's.

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. It was evident staff saw people as individuals.

The privacy and dignity of each person was respected by all staff and people we spoke with confirmed this. We saw that staff knocked on people's doors before entering, and that care plans outlined how people should receive care in a dignified manner. One member of staff said "We respect the privacy and dignity of people by simple things such as closing the door when they are getting changed or standing outside the bathroom facilities waiting for people in case they need further help." A second member of staff said, "I won't discuss personal information about a person with other relatives or other people. Confidentiality is very important".

Good

Is the service responsive?

Our findings

We examined four people's support plans and daily records. They were legible, and securely stored. They were person centred. People's choices and preferences were documented. We noted there were extensive personal and social histories were contained within them; it was possible to 'see the person' in support plans. The care staff we spoke with were knowledgeable about the people they were caring for.

People and their relatives were continuously involved in the assessment and planning of their care through regular review meetings. Throughout our inspection we observed that staff supported people in accordance with their care plans.

People were supported to follow their interests and take part in social activities. Some people attend a day service where they could socialise with their friends. One person said, "I go to day services on my own to see friends." One person liked football, their parent had arranged to take them to local football matches when they went home for the weekend, and the registered manager told us that there was a local football team very near to the home and they were arranging for them to go those matches. The registered manager told us that activity plans or 'flow of the day planner' were being introduced. We saw the minutes of the staff meetings in February 2018 where these had been discussed. The manager and staff felt that these would help people plan their day for example knowing that between 10am and 12pm was their time with staff and they could then choose what they wanted to do. One person told us they were unable to go abroad on holidays; they told us their care plan had been adjusted; "So I can have a full week of interesting activities and day trips instead".

Staff were actively involved in supporting people to engage, promote and build key relationships with family and friends outside of the service. One person told us, "My family come to visit me. The staff are very nice to my family." We were told that activities were individualised. One member of staff showed us 'memory books' that had recently been started by staff in one bungalow. They explained, "They are to show parents of [Name] and [Name] what they have been up to." Another member of staff told us it was "[Name's] dad's 70th birthday today and we sent him a birthday message and are going to give him a collage of photos in a frame at the weekend."

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Staff showed us some "expression pictures" and a key ring full of pictures and words to use with both people in one bungalow. The expression pictures were "angry, sad, happy and unsettled/anxious". Staff said "Yesterday we had the community nurse here to help with [Name's] mood. They were asked to point to the expression they were feeling. They pointed to the 'happy' one and their behaviour seemed to show this." We showed one person some of the pictures. One was "walk" – with a picture showing walking. They grabbed our hand and led us to their bedroom. Staff followed us and asked [Name] what they wanted through a

process of questions and indications the person showed staff they wanted to go out for a walk. They carried on in this manner with shoes and a coat. They then left to go for a walk.

We observed in one bungalow a person's DVD came to an end. They tried to tell the staff something which they could not understand. The member of staff asked [Name] to show them. They were able to get up and show them they wanted another DVD on. They were also able to tell them what they wanted for lunch. We saw one person enjoyed pampering sessions. They had several creams and staff explained they liked these on their face, hands and in their bath. [Name] showed them to us in her room and indicated they wanted some on their hands before going out.

The support plans we looked contained relevant and up to date information. For example, we noted one person occasionally displayed verbal and physical aggression to staff. We noted there was a behaviour support plan in place, outlining in detail possible triggers to behaviour and instructions to staff on how to de-escalate situations and keep people safe. Incidents were recorded on behavioural charts and the provider had sought advice from the Community Team for People with Learning Disabilities.

We noted support plans also contained a section entitled 'Health File'. This contained information related to the health and wellbeing of individuals. For example, one person's health file contained a section entitled, 'Personal issues for women', which provided information for the person and staff around areas such as breast examination, menopause and safe sex for people with learning disabilities. These were highly individualised and relevant to the support of the person.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke to knew the needs of each person well. Staff spoke to us in an open manner about how people were supported to express their sexuality and demonstrated respect for people's rights, choices and privacy.

Staff were able to describe the behaviour people showed if they were upset or unhappy and told us they would support the person to explore what was upsetting them so it could be addressed. Staff said they felt comfortable speaking to the registered manager if they had any concerns or wished to raise a complaint and were confident that any concerns raised would be taken seriously and appropriately dealt with. We noted the complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies. The complaints procedure was also available in an Easy read format, which we saw. The staff we spoke with were clear about their responsibilities in the management of complaints.

The complaints log showed that two complaints had been received in the last year. There were procedures in place to deal with complaints effectively and records were fully completed with a lessons learned section so that the service could use the outcome of the complaint to make improvements at the service.

We discussed end of life care with the registered manager. They were aware that care plans needed to hold this information however, they had found that some parents of people using the service were not ready to have these discussions. They did have this information in place for a few people.

Good

Is the service well-led?

Our findings

The registered manager had been at the service since May 2017 and was moved there after the previous manager had left and to manage the service through change following several safeguarding concerns. An inclusive positive culture had been developed at the service. Staff we spoke with felt able to express their opinions, felt their suggestions were listened to and felt able to contribute towards service delivery and development. The staff told us the registered manager was "hands on" and there was a team approach towards supporting people. The registered manager said, "We've got a really good team."

With all those spoken with, there seemed to be a good level of moral and sense of teamwork in each of the homes. The atmosphere was quite relaxed in each home. One member of staff was very enthusiastic and excited about the sensory room and explained this was their project. They explained what else she was thinking of adding – bead curtains, glow in the dark stickers, and that she "felt supported to go ahead." Another member of staff said, "I am happy working at Hill Lodge and I know the guys well." We observed them laughing and joking with people.

The staff showed a willingness to learn new specialist skills, such as Makaton in order to benefit the needs of the people. Staff shared with us their happiness in the openness of the registered manager and how things had improved at the service since the previous manager had left. A third member of staff told us they found working here "Fun and rewarding". They added "I can get very stressed but they make sure I am well supported here". A fourth told us, "I wouldn't go permanent as I am at the age I don't need to but I love working here. Everybody is always helping each other out. They work well together." They added, the manager and deputy were "Very approachable".

The registered manager was aware of their registration responsibilities and submitted statutory notifications about key events that occurred at the service as required.

People were unable to provide verbal or written feedback to staff about their experiences of the service. Staff used their knowledge of people and observations of their behaviour to identify what they enjoyed and if they were upset or worried. Relatives and other health and social care professionals were asked to express their views of the service through completion of an annual satisfaction survey. The results of the survey we looked at included actions needed and taken such as: Going out more – Activity timetables to be implemented and new activity board. Like to see my mum more - Arrangements made with this service user's mum to have more contact. Would like a new bed – research and purchase new bed with the individual. People's feedback was acted on.

The provider had systems in place to review, monitor and improve the quality of service delivery. This included a programme of audits and checks such as, reviewing medicines management, quality of care records, support to staff and environmental health and safety checks. We looked at audits undertaken by the provider, for example medicines. We noted there were a variety of daily, weekly and monthly procedures in place in all aspects of medicines management. We noted issues arising as a result of audits were dealt with in line with the provider's policy, in the form of detailed action planning.

Staff had signed to confirm they had read the provider's policies and procedures. From speaking with staff we identified their knowledge was up to date with good practice. We noted this was followed up in team meetings where staff were reminded to 'read and sign guidelines'.

The manager shared a business improvement plan with us showing how they were going to develop the service, part of the plan included the maintenance of the service and emergency plans.

The registered manager and provider worked with other agencies. This included the local authority and clinical commissioning groups who funded people's care. The registered manager kept representatives from the funding authorities up to date with people's care and support needs and where there were any changes in their health. Staff informed the funding authorities about how funded one to one support was used. The registered manager also liaised with other departments at the local authority in order to support people and their staff, including the safeguarding adult's team.