Tailored Transitions Ltd

Fernside

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 19 January 2018 and was announced. This was the service's first inspection having opened in April 2017.

Fernside is a small residential care home without nursing that provides support for up to 4 people aged 18-65 with complex medical, physical and learning needs. It is located in a purpose built bungalow with a large level access garden. At the time of our inspection the home was providing support to four people. People in care homes receive accommodation and nursing or 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.

This is the first care home for provider Tailored Transitions Ltd. The service was created by the registered manager and the nominated individual. 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. A nominated individual is a person who is responsible for supervising the management of the regulated activity that takes place at the location. Both the registered manager and nominated individual are registered learning disability nurses with a total of 14 years' experience in the care sector.

The care service at Fernside has been developed and designed in line with the values that underpin the Registering the Right Support 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. Registering the Right Support CQC policy

There were enough staff to keep people safe and meet people's individual needs. There was a safeguarding policy and procedures in place to protect people from abuse and harm. Staff understood their responsibilities to safeguard people and knew how to raise concerns both internally or externally if required. Staff had a good understanding of people's individual risks and how to manage them positively without being unduly restrictive. There were processes in place to ensure safe recruitment of staff to reduce the risks to people living at the home.

People were supported by staff with the skills, knowledge to meet their individual needs. There were processes in place to ensure staff had a robust induction to the service. Staff competency was monitored on an ongoing basis through observation, appraisal, and supervision. Staff received mandatory and bespoke training that enabled them to meet people's complex needs. Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people there. This provides protection for people who do not have capacity to make decisions for themselves.

Staff interacted with people in a kind, inclusive and positive way. There was a relaxed and happy atmosphere at the home with staff observed giving their time and responding to people in a patient and timely way. People's right to privacy and dignity was respected. People were supported to maintain relationships with relatives and friends and actively participate in community events. Staff demonstrated a good understanding of the people living there including their backgrounds, needs, abilities, preferences and wishes. People's support needs were identified, assessed and documented in personalised care plans.

People's care needs were assessed, monitored and regularly reviewed with their involvement, people important to them and healthcare professionals. The provider had established excellent relationships with healthcare professionals and relatives who were contacted and involved in a timely way to meet people's complex and changing needs. Relatives felt listened to and involved in their loved one's lives. Visiting professionals said the staff were pro-active and were always open to trying support alternatives wherever this was in people's best interests. People's desire for independence and meaningful activity was met through a varied range of activities tailored to their abilities and tastes. This allowed them to lead full and active lives and play a role in the local community.

With involvement from families and healthcare professionals, people had been supported to obtain bespoke technology which had enabled shared interactions, skill development a sense of achievement. People received support in a way that acknowledged and promoted equality and diversity. It recognised their needs as individuals, as part of a family, and as part of a small community of people living in the same home. The provider had a complaints policy and relatives knew what to do should they need to complain. When issues were raised staff were receptive and made changes to resolve things.

The management had the skills, knowledge, vision and drive to manage the service well and to identify where it could be improved. They were able to draw on their experience as registered learning disability nurses and this had generated confidence in them from relatives, staff and healthcare professionals. There were systems and processes in place to effectively monitor and evaluate the service provided. The managers viewed the home as a learning environment and this was demonstrated through a culture of shared learning across the team. The management were supportive, visible and open to ideas from staff.

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.

There were enough staff to keep people safe and meet people's individual needs.

There was a safeguarding policy and procedures in place to protect people from abuse. Staff understood their responsibilities to safeguard the people there and knew how to raise concerns.

Staff had a good understanding of people's individual risks and how to manage them.

The provider had safe recruitment procedures in place to reduce the risks to people living at the home.

Is the service effective?

Good

The service was effective.

People were supported by staff with the skills and knowledge to meet their individual needs. Staff competency was monitored by induction, observation, appraisal, and supervision.

Staff received training that enabled them to meet people's complex needs.

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people there.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a kind, inclusive and positive way.

People's right to privacy and dignity was upheld.

People were supported to maintain relationships with relatives and friends and actively participate in community events.

Staff demonstrated a good understanding of the people living there including their backgrounds, needs, abilities, preferences and wishes.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed, monitored and regularly reviewed with their involvement, people important to them and healthcare professionals

Healthcare professionals and relatives were contacted and involved in a timely way that helped the service meet people's complex needs.

People's need for independence and meaningful activity were met through a varied range of activities.

The provider had a complaints policy and relatives knew what to do should they need to complain.

Is the service well-led?

Good

The service was well-led.

The management had the skills, knowledge and drive to manage the service well and to identify where it could be improved.

There were systems and processes in place to effectively monitor and evaluate the service provided.

Management were supportive, visible and open to ideas from staff.

The provider sought views about the service from relatives, staff and health care professionals.

Relatives and health care professionals expressed total confidence in the management and staff.

Fernside

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 19 January 2018 and was carried out by two inspectors. The inspection was announced. We gave the service 48 hours' notice of the inspection visit because it is small and we needed to be sure that the manager would be in.

Prior to the inspection we contacted a speech and language therapist and a community learning disability nurse for feedback on their contact with the home. In planning the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

People using the service could not speak with us. We spoke with four people's relatives and observed how staff supported them to help us understand their experience. We spoke with the registered manager, nominated individual and three care staff.

We looked at all four peoples assessment and support plans. We also looked at records relating to the management of the home including staff rotas, medicine administration records, meeting minutes, and the recruitment information for four staff.

We pathway tracked two people by looking at their care plans and observing if they were supported in line with their assessed needs.

Good

Our findings

Staff knew what their safeguarding responsibilities were, what signs of abuse or harm to look out for and how to raise a concern. Staff told us they knew how to whistleblow should they need to and directed us to a noticeboard giving information on this. All staff had received equality and diversity training.

People's risks were assessed and staff were aware of the plans developed to manage these risks. For example, two people had a medical condition which required staff to administer emergency medicines in certain circumstances. Their support plans provided specific information for staff to respond to these medical emergencies and staff understood these. Peoples needs were assessed before they moved in to the home and plans were agreed to ensure the safety of their move. A relative said the move for their family member had been, "managed very well".

Equipment was routinely serviced. The home employed a maintenance person and all defects were recorded in a maintenance book. Repairs were tracked and outcomes recorded. Once a month the management conducted a health and safety tour of the home to identify issues that may have an impact on people, staff and visitors.

The home had enough staff to keep the people safe and had no vacancies. Staff told us there were always enough of them to meet people's needs, keep them safe and have time to speak with them. Relatives told us that they felt their family members were safe and well looked after. One relative said this was because of the management's experience of supporting people with learning disabilities. Staffing rotas showed that there were sufficient staff to meet people's needs and to respond flexibly when their needs changed. The day's rota matched the staff that were on shift during the inspection. The provider told us that it had a strict no agency policy and instead used four bank staff when required. This supported consistency and meant people received care and support from staff familiar to them. The provider has held coffee mornings for day and night staff to meet so they get to know each other and help build and maintain a cohesive team.

The provider had robust recruitment practices in place. Checks had taken place to ensure staff were suitable to support vulnerable people. Pre-employment and criminal records checks were undertaken. Records included photo identification, application forms with details of work history and qualifications, interview records, confirmation of eligibility to work in the UK and two verified references.

Medicines were managed, administered and stored safely by staff who were trained.. Staff rotas identified who on each shift had overall responsibility for medicines. Staff were able to tell us how they managed

medicines safely, for example, what they would do if a person had an adverse reaction to their medicines. Records clearly showed when people had not had their medicines and the reason for this, for example, on GP instruction or a person was asleep. Staff had access to information about medicines.

Where a person required time specific medicines, Medicine Administration Records (MAR) showed there had been no delays with this. People's MAR had photo identification to help staff cross reference with the photo on the actual medicines. 'As required' medicines (sometimes referred to as PRN) were recorded on separate PRN care plans and the person's GP notified if this type of medicine was needed for an extended period. For example, staff contact the GP if a person has had as required pain relief medicines for more than four days. We saw evidence that a physiotherapist and GP had been contacted in a timely way and had visited every two days when a person had been experiencing pain. This resulted in a change to the person's medicines. PRN sheets included details of what the medicine were for, the dose and how it should be taken. Instructions for the application of people's topical creams were detailed and included a body map noting where, how often and when it was applied and the amount to be used.

Medicines were stored safely and securely. Designated staff held the keys to the medicine storage areas. Medicines in use were within their expiry dates and bottles of liquid medicine had the date of opening recorded. Temperatures of the medicine storage, including refridgerated storage were checked regularly (and these were within a safe range?). Stock was ordered by the registered manager and returned to the pharmacy when no longer needed.

The home was visibly clean and was free from odours. The home environment was in a good condition and well maintained. The two downstairs shower rooms and toilets were clean, uncluttered, and had supplies of hand gel and personal protective equipment such as gloves and wipes. Laundry was done in an outside utility room. There were colour coded mops for floor cleaning to prevent cross contamination. The home had an infection control policy and all staff had received training in infection prevention and control. The service had a weekly cleaning schedule which was audited.

Accidents and incidents were recorded. The information was used to resolve issues and reduce the chance of them happening again. For example after an incident involving an individual's feeding equipment all relevant people had been informed including the person's relative, the GP and the safeguarding team. The person experienced no harm and was supported to have the equipment repaired. The staff team were made aware of what happened and then developed an alternative method of hanging people's feedbags to stop them catching on things in future.

Good

Our findings

People had their needs thoroughly assessed on arrival at the home. This was informed by their pre-assessment and needs specific to the new environment. Pre-assessment included understanding people's needs and the potential impact of these on people already living at Fernside. This helped give an overview of the complexity of needs and what the service needed to provide to support them effectively.

We observed staff offering people choice during our inspection including what they preferred to drink and what activities they wanted to do. One person had been supported to go for a walk but as it was windy they had indicated they wanted to return to the home and chose to watch a film instead. The managers told us that they were always keen to try out and explore new ideas for people with relatives consent. For example staff had observed that one person had communicated by their facial expression that they liked the smell of coffee and hot chocolate. A best interest decision meeting was held with the person's relatives and a risk assessment completed to reduce the risk of aspiration. This approach led to the person being supported to enjoy these drinks for the first time.

Staff received a comprehensive induction and had completed training including privacy and dignity, enteral feeding (this is feeding through a tube inserted directly into a person's stomach), and moving and positioning. Each new starter had received probationary reviews to check their progression and competence to support people's complex needs. Staff told us that they felt supported from the beginning of working at Fernside and that they had received "lots of training" which helped them do their role well and with confidence. Staff records clearly detailed where people were working well in their roles and identified where they needed to improve their knowledge and practice skills. They explained that rather than generalised training they received training relevant to the people living at the home. The registered manager said that staff training included a sensory impairment awareness session where staff had a simulated experience of what that meant for the people they supported.

Training was done by a variety of methods including face to face, online, completion of workbook topics and competency checks. Competency checks covered areas such as enteral feeding, chest physiotherapy, suppositories, the use of oxygen, and ventilation. The majority of staff had attained a qualification in health and social care. Supervisions were held 6-8 weekly and demonstrated two way communication and time for reflection. One staff member said that supervision always included a discussion about training that would develop staff roles. Interim supervisions were held when needed.

People were supported effectively to eat and drink and risks were managed effectively. We observed this

person being supported to have a drink thickened to the consistency outlined in their care plan. Support was given at the person's pace and in a relaxed and calm way. Some people had their nutrition through an enteral tube. This is a tube that goes directly into a person's stomach. Staff had specific training on how to manage this. People's food and drink were closely monitored. People were weighed regularly to identify weight loss or gain which could be used to inform decisions about the need for specialist advice for example from the speech and language team, GP or dietician.

Each person had a hospital passport that they took with them when accessing other services. The passports included information on people's communication needs (for example "rely on people that know me"), family and GP contact details, support needs, and signs of anxiety and pain.

When some of the people moved from living at home to Fernside their care staff shadowed the staff at their new home for six weeks to provide a smooth transition and continuity of approach. The registered manager told us that two of the staff that provided shadowing had decided to stay at Fernside. This meant that although people were in a new environment they had the familiarity of care staff that they had known before. Staff were also able to grow into their new role of supporting the people who had moved to the home.

People were supported to access health services including local hospitals, dentists and GP surgeries. Each person remained with their previous GP on moving to Fernside so they had continuity. This also reinforced the fact that they were individuals and did not have to reregister under one local GP surgery.

The service is provided from a spacious, purpose built bungalow with level access inside and outside in the large garden. Relatives were consulted to ensure their views were taken into account around the design of the home including layout, door widths and overhead hoists. The registered manager told us that all four people were identified before securing the property. This meant the bungalow was designed to fit the specific needs of the people that intended to make it their home.

Staff understood the principles of the Mental Capacity Act 2005 and how it applied to the people there. They were able to tell us when and who they would involve if a person lacked capacity. 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.
The provider had applied for Deprivation of Liberty Safeguards (DoLS) for all four people living at the home and was awaiting outcomes on these applications.. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
Where people were assessed as lacking capacity to make an informed decision on a particular issue best interest decisions had been made with relatives, staff and health care professionals. For example, people's relatives had been involved in decisions such as medical procedures and holidays. All staff had received training to understand their responsibilities under the MCA and DoLS and were able to confidently tell us how they sought consent and worked in people's best interests.

Good

Our findings

Due to people's communication needs we were unable to obtain their views but we observed each person smiling and reacting positively whenever they were supported by staff. Staff spoke with them in a friendly and compassionate way and it was clear that they had a good understanding of the people they were supporting. Interactions were natural and warm and there was a relaxed and happy atmosphere. Staff responded to people in a patient and timely way. We observed one of the people and a staff member doing a home activity together with the use of a personalised switch. This is assistive technology which helps people to operate equipment and interact with their environment. This enabled the person to take part in vacuuming their own room. One relative told us that [name] had been able to contribute to a baking activity using this technology. Another person used their switch to make their relative a hot drink when they visited. These activities increased people's skills, sense of inclusion and built rapport between the people and staff. One relative said, "My [relation] is not just living here. [They are] thriving."

People living at the home were non-verbal. Decisions about their care and support were based on a robust understanding of their body language alongside regular discussion with their relatives. One of the people did not use technology to communicate their needs. Instead staff did choice work with them. For example staff showed the person two versions of the same type of clothing to choose from. They had recognised that this person was more engaged later in the day than in the mornings and so did more choice work at that time.

To help maintain people's privacy and dignity when being supported in a downstairs shower room there was a curtain that is pulled across the doorway. This meant that if the door is opened the person's privacy and dignity is maintained. When giving intimate personal care staff told us that they cover people with a towel and only entered a room after knocking. To respect people's right to privacy staff used the side entrance to the house on early morning shifts. This reduced the risk of disturbing people sleeping at the front of the house.

People were supported to be individuals. For example, people attended a local day centre when they were ready and used their own transport driven by care staff. Staff understood that, no matter whether in the home or eating out, some people preferred to eat their meals in company and others in a more private setting. One person's care plan detailed their preferences in this area of their life for when they ate out at restaurants. Every person's bedroom was spacious and had been personalised with family involvement. Relatives told us their family member's bedroom reflected their own tastes and individuality. Bedrooms contained lots of photos of people's family, friends and objects important to them. Mirrors were placed at a

height that enabled people to see themselves and check on their appearance from their wheelchairs.

The home understood its obligations under the Data Protection Act and kept all records secure. Staff were encouraged to have no more than seven days of daily records in care plans and to keep these stored securely. We saw that this was adhered to. Access to computer records was password protected and equipment was never left unattended.

Good

Our findings

Each person had a care plan that was personalised to meet their individual needs. These plans were developed in partnership with relatives, staff and healthcare professionals and reviewed and revised as people's needs changed. Care plans clearly documented how staff could communicate effectively with each person. For example one person's plan advised staff that the person communicated using head and eye movement. It noted that this person got staff attention by coughing then looking at an object in a room. Additionally the care plan advised staff to position [person] so that they could see everything around them. When this person wanted somebody to leave a room they looked at the person then at the door. Staff understood the people well and so were able to meet their needs by interpreting and responding to their facial expressions and other cues from their body language.

Due to people's complex needs easy read versions of written information were not appropriate. Instead staff used objects of reference to introduce choice or to let people know what would happen next. For example staff used photos on a person's tablet computer to check whether the person wanted to go to the day centre or see family. The tablet computer also had images of emotions on it to enable the person to express how they felt and to indicate whether they had enjoyed an activity. When shopping and choosing items, for example when choosing a product to use on their body, for example shampoo, people were offered two options via smell and their response would indicate their preference.

Relatives said that they felt fully involved and consulted about their loved ones care needs and reviews that took place. One relative said, "There is open communication. Any queries they consult me. I feel 100% involved." Another relative told us, "We couldn't have asked for anything better. They are brilliant. We feel very much involved." Another said "we feel confident they are genuinely looking after [person] and responding to [person] needs. They probably know [person] better than us."

People had access to specialist equipment that supported their health and independence. This included specialist wheelchairs and electronic switches to enable participation in activities such as vacuuming and baking Some people had brought their own switches in from home and other people had been supported to try out switches according to their specific needs. The registered manager and nominated individual had previous experience of people using switches and so had been able to advise relatives about how these could benefit their loved ones in terms of shared interactions, skill development and participation. One person had received a certificate of achievement from the home for using their switches. This meant people's skills were recognised and they were motivated to use them.

People were supported with a variety of activities according to their taste. These included massage, helping with a local food bank, and nightclubbing. Relatives told us that staff had supported their loved ones to continue activities they had enjoyed before moving in and had encouraged them to try new things. The back of daily logs recorded what activity a person had done and whether they had enjoyed it. These logs and audits also meant that people's activity schedules could be amended to reflect what they currently enjoyed. One relative told us how happy they were that their relative was "doing far more activities than when at home." The provider kept a pictorial activity log by the entrance which enabled people to remember some of the activities that had taken place. Staff recognised that some people likes celebrating certain events and seasonal festivities and others were not as keen. On these occasions alternatives were offered and supported.

There was a strong emphasis on maintaining relationships with relatives and friends and participating in community events and groups. We saw photos of people enjoying various activities with relatives and friends that had taken place both inside the home and in the community. These included BBQs and friend's birthday parties. The service supported people to be actively involved in and build strong links with the local community. This had included a beach clean-up day and the local Neighbourhood Watch group. Relatives told us they are able to visit without restriction and always felt very welcome. People's files included group living plans. This meant that people were not only seen and supported as individuals but consideration was given to how people interacted with each other in the same home.

There was a visible complaints procedure known to relatives and staff. Since opening in April 2017 the provider had not received any complaints. Relatives and staff told us they knew how to complain and had confidence that they would be listened to and action taken to resolve issues. Relatives told us that they had no concerns with the service that their loved ones received. One person's relative told us that when they had informed staff that her loved one's mobility chair had become soiled with medicine the chair was immediately added to the nightly cleaning list.

Two people had an advanced care plan. These had input from relatives and were signed by the relevant person's GP. The registered manager told us that discussions had taken place with the other people's relatives but they had decided not to consider advanced care planning at this time. One relative confirmed that staff support people at the home to follow their faith.

Good

Our findings

The registered manager worked closely with the nominated individual. They were both passionate and committed in supporting the people at Fernside to receive quality care and support that recognised their uniqueness. The managers' hands on approach was evident during our inspection and was seen as a positive by the staff. One relative commented that prior to their loved ones move to Fernside they already knew of the nominated individual due to their "good reputation." One staff member said they felt "really supported" and that working at the home was "much better than I even thought it would be." Other staff told us it was a relaxed and a "fun place" to work. Staff described the culture as "happy, open and honest" where they felt "valued and trusted."

Staff felt able to raise things freely with the managers and that they then used this information to improve the service that people received. In one instance this resulted in people living with epilepsy having stopwatches discreetly fitted to their wheelchairs. This meant that if a person experienced a seizure staff would be able to use the stopwatch to time the duration of the seizure and respond accordingly.

The managers demonstrated a robust understanding of their roles and their responsibilities with regards to CQC requirements including an awareness of when to notify us of particular incidents or events affecting the service. Staff commented positively about the communication they received from the managers. One relative said the registered manager and nominated individual were "excellent in liaising with us. The communication is good. We get timely responses [and] they are always open to meeting with us."

The staff noticeboard included the provider's vision and mission statement and upcoming training. There were effective lines of communication in place including staff handovers and a communication book which gave staff the opportunity to share important information. Minutes of staff meetings held included discussion around people's upcoming hospital procedures, securing people's safely in their mobility vehicles, changes to feeding regimes, managing soiled laundry at night, and supporting a person's posture. Staff meetings were well attended and staff signed to confirm they had read and understood the minutes.

Staff knew when they had performed their roles well as management told them this both informally and formally. One staff member said that they felt "incredibly supported by the managers" and then added "they want the best for everyone – staff and the people living here." The managers had marked occasions where staff had worked together well by treating them to a fish and chip supper and also thanked each individually with personalised gift vouchers. One staff member told us they felt appreciated after they had received "a big thank you and a box of chocolates" from the managers after supporting one of the people during a day

at hospital.

One relative said they felt welcomed whenever they visited the home. they said that when their loved one had required a new piece of equipment they were invited in to meet the physiotherapist to talk through its benefits and any concerns. This person added that "management always have time for you. Communication is good and timely. I couldn't believe we found this place. We couldn't ask for anything more than what we have here." Another relative said the managers "always check our views. I would give the home 10 plus out of 10." Other relatives told us there was a good relationship between the managers and staff. One staff member said "I love it here. It is a breath of fresh air." Another said, "I feel very much valued and listened to."

The home encouraged and valued feedback from people, relatives, staff and health care professionals. It sent out questionnaires every six months to relatives, staff and health care professionals. One professional had written 'open more homes please. I would highly recommend Fernside without any hesitation. We need more services aimed at young people such as this. A shining example.' A staff member fedback that 'people are able to put forward ideas and contribute to activity and routine planning for [the people living here]. I have faith that the management team will always strive to improve services and avoid becoming stagnant in delivering the best.' One person's relative advised 'they have discussed any concerns we have and appreciate we know best.' The managers said their biggest achievement had been seeing their vision work and knowing that people and their relatives were happy with the support provided. One of the healthcare professionals said they were "struck by how pro-active the managers are at meeting the complexity of need" adding "I would place a relative there without a doubt…I am very impressed at how well led it is by the managers."

The managers said that they viewed the home as a learning environment. There was a culture of shared learning across the team. For example two staff who had attended a recent training course were booked to feedback to colleagues at the next team meeting on what they had learned. Learning from incidents was drawn out and shared with the team in a way that did not identify members of staff. This protected staff from discrimination and encouraged them to be open and honest.

The home used an external agency to keep their policies up to date. Policies we viewed covered areas including safeguarding, Deprivation of Liberty Safeguards, medicines, and the Mental Capacity Act. The provider told us that staff logged onto a policy page to read the relevant documents and management could check electronically that this had been done. Staff also used their own phones to read the policies.

Every month the home did a monthly activity outcome audit to see if people had benefited from what they had done. This had shown that an external yoga teacher was not the best fit for the needs of the people at the home. One of the relatives advised the managers of somebody who might be more suitable and this person is currently being trialled. The provider had a regularly updated Facebook page where relatives, friends and staff are actively involved and where people have commended the service that is provided.

The managers told us that an architect was booked to visit the home as they planned to extend the utility room so a hot tub can be installed. This would provide freedom of movement and hydrotherapy for the people all of which, due to their needs, spend extended periods during the day in their wheelchairs. The home had a working action plan. This detailed the identified action, action to be taken, steps to ensure this was met, timescales and the responsible person. An action within this plan included an audit of a person's fluid intake as this was seen to fluctuate. The home used this information to determine if there were trends for example on days the person was more active.

There were robust assurance systems in place to ensure people received safe, high quality and

compassionate care. This included medicines, care plan, accident and training and activity audits.

The managers told us they were reviewing the strengths and weakness of staff members in order to determine the best key worker for each of the people living at the home. As with initial consultation regarding the design and layout of the home, this was further evidence of the service prioritising people's needs ahead of any other consideration. The managers had also started to identify staff keen to become oral health champions as this was an element of care sometimes overlooked in learning disability services.

The provider had strong working relationships with other services and organisations including respiratory care and the NHS continuing health care team. The respiratory team at a local hospital had provided training to staff which had given them the skills to support one of the people with complex needs in this area. The managers told us that they attend nursing network conferences, local learning disability nurses networks, a regional quarterly epilepsy meeting, a learning disability forum run by the local authority, and were signed up for updates on employment law, health and safety, and medicines practice. Both managers were doing a diploma in health and social care and had completed an accredited management course. They told us that in developing and managing the service they drew on their "passion to empower people and help them live the best life they can", their previous experience of being registered learning disability nurses and their time mentoring student nurses. Staff told us this background made them confident in them as managers. They told us that they had been motivated to put together bespoke training for other providers due to the lack of training courses available to meet the needs of people with such complex needs.