The Royal National Institute for Deaf People

Harding House

Inspection report

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Date of inspection visit:
31 May 2017
01 June 2017

Date of publication:
06 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Harding House on 31 May and 1 June 2017. The inspection was unannounced on the first day and we told the provider we would be returning on the second day. Our last inspection took place on 26 and 31 August 2016 where we found four breaches of legal requirements in relation to safe care and treatment, dignity and respect, person centred care and good governance.

Harding House is registered to provide accommodation and personal care for up to 10 people who are deaf with mental health needs. Action on Hearing Loss provide the care and support and the accommodation is owned by a separate landlord. At the time of the inspection there were seven people living in the home.

The service had a registered manager who was present on both days 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.

Staff had a good understanding of their responsibilities in relation to keeping people safe from harm however the provider did not notify us about an allegation of abuse.

There were enough staff deployed to meet the needs of the people and the results of background checks on staff showed that they were suitably employed.

Medicines were administered and stored safely, however medicines records and audits required further scrutiny. The provider carried out assessments to ensure staff were competent to manage medicines.

Staff training was regularly updated to keep their skills and practice updated and staff signing skills had been reassessed. People told us there had been improvements with the staff team's signing skills.

People were involved in choosing their own foods and they were provided with a well balanced diet. Staff supported people to adhere to effective food hygiene practices and healthcare services were accessed to regularly monitor people's health.

The provider followed the legal requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People told us they were listened to by helpful and kind staff. They made their own decisions and choices about how they received their care. Staff understood how to meet people's individual needs and respected their privacy and dignity. Advocacy services were accessed to make certain people's views were listened to.

Care records were personalised and people's relatives were invited to reviews when people requested this. Staff held regular meetings with people to discuss their individual needs and help them attain their goals.

Information about how to complain was available to meet people's communication needs and they told us they had no concerns. People were confident any complaints they raised would be resolved.

The provider had involved people in how the service could improve and to ensure lessons were learned, and were committed to making improvements. Audits were carried out but further scrutiny was needed to address the shortfalls we found. People and staff were content with how the home was run.

We have made one recommendation about the safe management of medicines. Further information is in the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not always safe.

People's medicines were administered and stored safely but some of the records did not reflect best practice on how medicines should be recorded. Medicines competency checks had been carried out on staff.

Staff knew the correct action to take to keep people safe from abuse. Information about safeguarding was accessible for people to read.

Sufficient staff were on duty to meet people's needs and recruitment checks had been obtained before they were employed.

Refurbishments had begun on the building to ensure the home environment was safe.

Is the service effective?

Good

The service was effective.

Effective arrangements were in place to ensure people received good nutrition and hydration.

Staff received the appropriate training and support to deliver good standards of care to people.

People's consent was sought regarding their care in accordance with the Mental Capacity Act (MCA) 2005.

People had access to healthcare services.

Is the service caring?

Good

The service was caring.

People told us staff were helpful and kind. Staff understood how people wished to receive their care and this was carried out a way that respected their dignity.

Advocacy services were used to ensure people's views were heard

Care was provided in a respectful manner and in the least intrusive way possible.

Is the service responsive?

Good

The service was responsive.

Care plans demonstrated how people's needs were met and relatives were involved in the reviews of these. Staff supported people with their hobbies and interests inside and outside of the home.

Complaints were responded to when people had concerns about their care, and people felt assured that concerns would be dealt with satisfactorily.

Is the service well-led?

Requires Improvement

Aspects of the service were not always well led.

The provider did not notify the Care Quality Commission (CQC) of a safeguarding allegation as required by law.

Quality assurance processes were in place to improve the service; however a more robust approach was required.

People and staff were satisfied with the management of the home. The management team were committed to making improvements.

Surveys had been sent to people to obtain their views, and people's opinions were sought to learn how the provider could continually improve.

Harding House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected Harding House on the 31 May and 1 June 2017. The inspection was unannounced on the first day and announced on the second day and carried out by one inspector. A British Sign Language (BSL) interpreter joined us at the inspection and spoke with seven people who lived in the home to seek their views about the care they received.

Before the inspection we reviewed the information we held about the service including the last inspection report and the provider's action plan. During the inspection we checked five people's care records, four staff files and records relating to the management of the home. We also spoke with four support workers, the senior support worker and the registered manager.

After the inspection we spoke with one relative to ascertain their views about the home.

Requires Improvement

Is the service safe?

Our findings

People were supported to receive their medicines safely, however documentation required thorough auditing to ensure that their medicines were managed safely. At our last inspection we found that medicines taken 'as required' were not managed safely and stock counts of medicines were not accurately recorded. At this inspection people told us they had no concerns with their medicines and received their medicines at the right time and this is what we observed. We conducted a tablet count of 'as required' medicines and found these to be accurate. When these medicines were given the reasons for this had been documented on the medicine administration records (MARs). Medicines expiry dates were documented and a note had been recorded in the dairy as a reminder to staff to dispose of one person's expired medicines and when to begin a new course of their prescribed medicines.

Medicines were delivered to the home by a pharmacist in blister packs, checked upon delivery and held securely in a medicines cabinet. Room, cabinet and fridge temperature checks were regularly recorded to ensure the safe storage of medicines. The fridge was locked and held only medicines that required refrigeration. Records detailed the appropriate information about people's medicines and any adverse reactions they may have to these. We checked five people's MAR charts and found that staff and people using the service had signed these to show when medicines had been administered and received.

Where people needed to their take their medicines when they were away from the home a transfer of medicines form listed the details of the medicines they had been given which were signed by people using the service and the staff member.

Surplus medicines were collected by the pharmacist to be disposed of. Records showed when this was done and these were signed by the staff and the person using the service, however this was not signed by the pharmacist to show the medicines had been received. Another record for a person's medicines had been signed by the pharmacist but the not the staff or the person using the service. After the inspection we received information from the provider to show that the pharmacist used a handheld electronic device to collect and store the signatures.

Staff had completed medicine competency assessments to improve their skills and knowledge about the safe management of medicines and what to do if any medicine errors occurred, however when staff made errors on two peoples' MARs they had not documented the reasons for this. We pointed this out to the registered manager who acknowledged this. We checked the provider's weekly audit which did not identify these issues and we found the medicines audits were not completed the previous week for medicines. We recommend that the provider seek advice from a reputable source about appropriate and accurate medicines recording.

People told us they felt safe using the service. Comments included, "The first time I moved here, I was quite lost, and panicky as I was not confident, then I got used to things, I feel secure, I like [staff name's] they keep me safe" and "I feel safe here but at night but it's very dangerous at night outside because there is too much

risk, no problems here though, I know who to talk to if I am scared about anything." A person's relative told us, "I have no issues or concerns, I just pop in and I tend to speak to the regular care worker I know [them] and am more comfortable talking to [them]."

Safeguards were in place to prevent and respond to allegations of abuse. Information the Care Quality Commission (CQC) had received showed that any concerns had been referred to the local authority for further investigation, however we found that the provider had not notified the CQC of an allegation of abuse as required.

At our last inspection we found that safeguarding information was not accessible to people who used the service. At this inspection information about safeguarding was placed in a central location so this was available for people to view, there were details to advise people who they could report their concerns to and staff reinforced messages during meetings with people about keeping safe from harm.

Staff were able to describe the different types of abuse and told us they would act on any information of concern if they suspected people were being or could be abused. A staff member commented, "I would report it straight away, there is no favouritism when it comes to abuse, if you're wrong, you're wrong." They understood the importance of following the whistleblowing procedures if they had to report any workplace concerns.

People's care needs had been assessed taking into account the risks posed in relation to aspects of their health care and physical well being and when they accessed the wider community. Written guidance was in place to show how staff would manage the associated risks and the impact this would have on people if the control measure and the risk guidelines were not followed. Lone working risk assessments had been carried out for staff, these required staff to diarise their working location, actions to take in the event of any emergencies and stated that these must be reviewed if the circumstances changed.

At our last inspection we found that areas of the home were poorly maintained and some rooms in the premises were not clean. At this inspection we checked the premises and all areas of the home, including the utility room and these were observed to be clean. Pictorial notices were visible to remind people to recycle their disposable waste. Rotas had been implemented to ensure staff supported people to keep the premises clean and tidy and these were signed by staff daily to show when the cleaning duties had been completed. The registered manager explained that a deep clean had been done in the building and the people we spoke with confirmed this. We checked the bathrooms on all floors and found that clinical waste equipment had been newly replaced and adaptations that were no longer needed removed. One person commented, "It's nice here but it's a very old building, my favourite place is my bedroom, I keep it tidy."

Records showed cyclical works were due to take place by the landlord to commence on repairs and refurbishments to the home in July 2017, this was to include work on the basement, windows and the replacement of carpets and we found that people were involved in choosing the colour scheme. Work had commenced on the basement of the home and external contractors had commenced some aspects of work in relation to the damp in the cellar; the walls were much drier. Documentation showed that the landlord was to recommence with additional repairs in July 2017. To ensure this area was safe, stored items had been moved into another room and two fire doors had been installed in the basement to adhere to fire safety regulations. Access to this area was restricted to staff only.

At our last inspection we found that the provider had not actioned all recommendations following a fire safety inspection. At this inspection we found that a fire risk assessor had attended the home to assess the building and make further recommendations about fire safety on the premises. Staff had received refresher

fire training and two members of staff were appointed to be the home fire Marshalls after completing the required training. Where people did not respond to the fire drill within an acceptable time, records showed they had watched a BSL video on fire safety training to make them aware of the danger fire posed to them by not responding to the fire alarm.

At our last inspection we found there was not enough staff to meet people's needs. During this inspection we found that the management team had reviewed staffing levels to assess the amount of staff cover required during the day and night to meet people's assessed needs. We observed the number of staff on site correlated with the staff rota. Consistency of care was taken into account, as the provider had recently recruited a new member of staff who had previously worked in the provider's other homes as an agency worker. The registered manager explained that at the last recruitment drive they did not identify suitable candidates and two posts were vacant. To address this the staffing hours had been revised and bank staff covered the additional hours. We observed that they had worked in the provider's other home and were familiar with people's needs and the staff team. People told us there was enough staff to support them when this was needed and staff confirmed this.

Recruitment records held the appropriate information to demonstrate staff background checks had been completed to assess the suitably of staff. Disclosure and Barring Service (DBS) checks had been done before staff were employed by the provider, two references were on file and staff identification had been verified to evidence that the documentation was authentic. Records showed that disciplinary procedures were followed to address staff conduct when this was necessary.

Good

Is the service effective?

Our findings

At our last inspection we found that people were not always supported to follow a well-balanced diet and good food hygiene practices were not always followed. At this inspection we saw that noticeboards had been updated with easy read information about the benefits of healthy eating, the importance of hydration and ideas about how people could stay fit and well.

People had access to communal kitchen facilitates on all floors of the home to store and cook their food provisions and food cupboards were labelled with people's names. We checked the fridges and found these to be clean, food items were stored and sealed appropriately and labelled with the date of opening. Pictorial information was in place about how to cook and store food safely and for one person a visual reminder about their mealtimes was posted on their fridge. The person explained, "I am learning about putting things in the fridge, I have a plan I have to reduce eating biscuits, I plan to lose weight." Records showed staff completed frequent checks to monitor the safe handling and storage of food.

Following a house meeting staff now supported people to cook an evening meal together daily in the communal dining area on the ground floor. People had been involved in choosing their preferred dishes and pictures of their favourite cuisines were placed on the menu. During the evening meal, we saw that the food served to people was based on what was on the menu for that day, people were given sufficient portions of food which they told us they enjoyed. A staff member said, "I think the choice of food has definitely improved, like help making better choices for individuals, healthy eating and just being mindful of their diets. It was their eating habits before, now we include more vegetables and we encourage them to cook and make things from scratch."

People chose to cook and eat their meals at different times of the day and staff were flexible in their approach to supporting people with this, we saw that people ate their meals at various times during the course of the inspection. Two people explained they were able to prepare quick snacks and drinks for themselves and purchase their own food groceries and commented, "I go shopping and buy food and some drinks, I like marmalade and raspberry jam" and "Staff help me cook sometimes, I can also cook myself things like toast with butter."

Care plans showed that staff had engaged people to choose healthy food options and records showed where a staff member had supported a person to cook soy orange chicken and pea mint soup. The staff member explained this was a huge achievement for the person who did not usually cook homemade dishes and commented "[The] person felt empowered [they] could do it and felt really proud of it." A healthy eating workshop was booked for people about food safety which was to be presented with picture messages and video clips. The registered manager told us the provider had links with a large coffee shop chain that provided free sandwiches to people.

At our last inspection we found that the communication needs of people were not met. At this inspection staff British Sign Language (BSL) skills had been reassessed to ascertain the effectiveness of their signing skills and check if they were ready to progress to an advanced level of BSL. People we spoke with explained

there had been improvements in the ways staff communicated with them and commented, "The staff sign alright, but sometimes it's difficult", "They are ok, getting a little better, I understand the pictures", " Staff signing is good" and "There is two deaf staff here, so communication is much better."

We spoke with staff about their learning needs and they described the different ways people communicated their needs and explained they also learned the different signs people used, and worked with people to understand how best to communicate more effectively with them. For example, one person agreed to use flash cards and one staff member had worked with another person with alphabet spelling to increase their confidence with their English skills. One deaf staff member told us, "We have a good laugh on the whole, they learn from learn me, particularly with [person's name] signing, which is different from mine. I was showing [the person] modern signs and [they] were showing me the old signs, I recognised the signs but the communication is still effective. [Person's name] is a finger speller and is amazing, I was shocked, blown away. We play word games with them; we match the words with the pictures and they do that well."

New employees had received an induction which involved them familiarising themselves with their responsibilities and duties and reading people's care records to gain a full understanding of their background and circumstances. Staff training was planned and organised to make certain they received training that was reflective of the needs of people who lived in the home. Records showed staff had attended training on a range of topics, such as first aid level two, mental capacity, safeguarding, sexuality awareness and supporting sexual expression, food hygiene and person centred care. Annual appraisals and supervisions had been completed with staff to discuss their experiences working with the people using the service and identify their learning needs based on staff feedback.

At our last inspection we found that staff had received regular supervisions apart from one member of staff. At this inspection we checked that the staff member had been supervised on a regular basis and we found that the registered manager had met with the staff member on three occasions since the last inspection. We spoke with the staff member who confirmed this but explained they communicated frequently with the registered manager and had attended informal meetings about their work progression. The registered manager agreed they needed to prioritise their time to conduct formal supervisions with the member of staff.

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. Care records showed where people had capacity to make specific decisions about areas of their care. Decision making agreements were held on people's files to show how staff should best support people to make decisions, who would be involved and who made the final decision, for example, in relation to people's finances and medicines. One person told us about the choices they were offered by staff and the decisions they made about their accommodation and said, "They have arranged for me to go and see another home in [name of place], that was my decision."

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 are called the Deprivation of Liberty Safeguards (DoLS). No one who lived in the home was deprived of their liberty and therefore no applications had been sent to the local authority in relation to a DoLS authorisation.

Healthcare professionals were involved in people's care when this was required such as podiatrists and social workers. Records showed that staff frequently liaised with the community mental health team to

discuss matters affecting people's healthcare needs and wellbeing. One person commented, "I don't have to see the doctor because I am not ill, I did go and see the doctor about my knee, but that was a while ago." Staff made referrals to healthcare services when people's health care needs changed and we saw that the advice that was given to staff was acted on.

Good

Is the service caring?

Our findings

At our last inspection people told us they were not always treated with kindness and respect. During this inspection people said, "[Staff name] is the best staff here [they] understand more, I am very quiet, all staff are very good", "They are kind and caring they help me a lot" and "Some staff are nice here some are just ok, but on the whole they help me with anything I need."

We observed that staff treated people with kindness and respect. We saw that hearing staff minimised the use of verbal communication with each other when in the presence of deaf people. The importance of eye contact and non-verbal communication to express and convey messages to people was maintained when signing with them. Written signs in the home were used as a reminder to staff to underpin this, for example, notices were displayed which read 'please use sign language and turn off your voice'.

We saw that when people asked for help staff readily assisted and people did not have to wait for support. Staff frequently interacted with people in the main communal areas of the home with warm pleasantries and laughter exchanged between staff and people who used the service. One person commented, "I am going to buy some new clothes, t-shirts and some bright clothes, staff help me with this, not sure what else? Oh, I want to buy maybe some new covers for my bed." One staff member had returned from a shopping trip with a person and was seen in the dining area admiring their newly purchased items whilst staff reminded the person to ensure safe keeping of these. To best support a person during a bereavement two members of staff had offered to support the person by attending the funeral ceremony when there was a delay with obtaining an interpreter to meet the person's needs.

At our last inspection we found that staff did not have a good understanding of people's care needs. At this inspection was saw that staff engaged with people to ensure their individual needs were met and people were involved in the decisions about the care they wished to receive. People spoke with us about their interests and what they liked to do. One person told us they were to take part in voting during the general election and, "The voting is coming up soon," and another person spoke about their exercise routine and said, "I like swimming I can swim, I have been with staff, I can do the backstroke."

Staff spoke about people's needs and the tasks they were able to do independently and the areas where they required more support. We observed staff worked in collaboration when discussing people's care needs and how they had supported people during their day. In response to one person's request to visit different places of interest with company but independent of staff, records showed staff had helped the person liaise with their social worker who had agreed additional hours of support for an outreach worker to accompany the person during their outings.

At our last inspection we found that people were not signposted to access advocacy support. At this inspection advocacy support had been accessed for four people who used the service, this was in relation to completing and understanding the provider's survey to obtain their views and opinions about the service and to support with people's employment rights.

People told us their privacy and dignity was respected and they commented, "They ring the bell before they enter my room" and "Staff know I always make sure I care for myself, they know they have to give me my privacy." As part of the provider's agreement with people staff conducted health and safety checks on people's rooms. Records showed that one person had asked staff to teach them specific skills to lessen the intrusion into their room at a particular time of the day and this was acted on. Staff had received training in dignity in care to understand their responsibilities and the importance of upholding the dignity of people in the home.

Good

Is the service responsive?

Our findings

At our last inspection we found that people's relatives had not been involved in care reviews. At this inspection records showed that relatives were included in people's reviews about their care. One relative told us, "I attended a meeting at the home with the social worker and staff, we take [family member] shopping for clothes and [they] come and visit me." Care records showed where families were invited to be involved and contribute to a review of people's care needs with their consent. Where people visited their families frequently we saw that staff had contacted relatives to ensure they had arrived at their relative's home safely.

At out last inspection we found that people could not recall being involved in decisions about their care, their care plans required updating and one to one meetings did not take place regularly. During this inspection we found that care plans had been developed in a format that was easy for people to read and understand, they included people's decisions and choices about the care they wished to receive. Regular one to one meetings had taken place with people and notes showed the decisions people made, the steps they had taken to achieve their goals and when their progress was reviewed. Records had been updated to show when people's circumstances changed so staff could be responsive to this. Some records still required reviewing but we found that the providers audit had identified these shortfalls in people's care records.

Staff spoke about people's aspirations and lifestyle choices and how they wanted to be supported. The hours people were to be supported by staff with their one to one care was noted to ensure people were provided with the care and support that met their assessed needs. Minutes of residents' meetings showed that people were given the opportunity to voice their opinions and express their views about the home, one person said, "We have meetings in the home here and If I want I can contribute."

At our last inspection we found that one person's personal preferences regarding specific gender care was not met. At this inspection we found that people in the home were supported to receive care from staff of a specific gender when this was requested.

At out last inspection we found that the activities people engaged in were not documented in their care records and an easy read guide was not in place to help people understand the expectations of the home. At this inspection we found records to show people had plans in place to demonstrate the activities and leisurely pursuits they were involved in. People had specific plans tailored to meet their individual needs and in relation to their hobbies and educational and employment needs. The registered manager showed us a draft copy of the pictorial service user guide that the provider was in the process of completing to ensure people understood the services that were provided to them and their responsibilities and rights whilst living in the home.

People described the things they enjoyed and their leisurely pursuits and told us, "I like going out on trips, to Brighton trips and London zoo, I go with deaf people. I have also been to Holland and Liverpool and Blackpool with deaf people and staff" and "I do English and maths and have certificates for them I go to different colleges, love to cook, I want to learn how to lip read." We observed staff remind a person they were

to accompany them to attend an open day at college the following day along with another person who lived in the home. Profiles of what people enjoyed most were displayed on the noticeboard and one person happily showed us a picture of their significant other who was pictured in their profile, whom they visited most weekends. Invitations had been sent to people in relation to an active and wellbeing programme facilitated by an external stakeholder, people told us they may attend this. During the course of the day we saw that a deaf gardener had arrived and people and staff gathered in the garden to plant flower pots along with people from the provider's other local home. A staff member commented, "We do make an effort to get involved in people's lives, we try to make their time here enjoyable and meaningful."

At our last inspection we found that there was no sign on the suggestion box to inform people what this was used for. At this inspection we saw that a sign had been placed on the box so people could understand what this was used for. People explained they knew who to complain to and were confident in the registered manager's ability to resolve any concerns they had. People told us, "I would speak to the manager if I had any problems" and "Obviously I'm confident in [the registered manager] and would talk to him private if I had a concern." To reinforce to people how to make a complaint, we saw information to show that a person had been shown a BSL video to understand how to make a complaint if they were dissatisfied with the service and who they could escalate the complaint to if this was not resolved satisfactorily. Since the last inspection we found that the provider had received one complaint and this was investigated and responded to within an appropriate timescale.

Requires Improvement

Is the service well-led?

Our findings

There had been one incident involving an allegation of abuse that had been sent to the local authority to investigate but not reported to the Care Quality Commission (CQC). The registered manager explained they had not reported this as they were waiting to ascertain if this was deemed as a safeguarding incident by the placing authority. We informed the registered manager about their responsibility by law to notify us of all safeguarding allegations irrespective of the outcome, the registered manager agreed to send the notification to the CQC in due course.

At our last inspection we found that audits were not implemented. At this inspection we found that medicines still required a more robust auditing system, for example the provider told us they had implemented weekly audits of medicines, but we found that the most recent medicines audit was carried out on 16 May 2017, the registered manager told us he was unavailable the previous week and agreed to complete this. Audits of medicines were completed by the registered manager and a representative of the organisation. These identified any anomalies or discrepancies found such as the ordering of repeat prescriptions, level of support people needed to be included in their care records and how risks should be assessed. However, these did not always pick up issues we found. For example, the recording of errors on the MARs and the specific dates these actions were required to be completed were not always recorded.

Audits had been completed on care records and picked up the issues in relation to errors and discrepancies on forms, for example, audits showed that some records required reviewing and where key information was incomplete and needed to be rewritten. Clear lines of accountability were recorded on posters in the office about which designated member of staff was allocated to complete the tasks in the home, One staff member commented, "We tend to document things a lot more, we are getting a lot better at that." The deputy manager was based at another home and stepped into support people in the home during the registered manager's absence and we saw that they visited the service on the first day of the inspection.

At our last inspection people told us they were not able to communicate effectively with the registered manager. At this inspection people told us, "He's a good boss he's alright, when I say good morning he seems to respond", "It's ok, the manager here is alright" and "Very good boss I like [manager's name], he is nice and signs sufficiently, he helps me a lot he's helped me move things in my room." We observed that the registered manager made a concerted effort to communicate with people who used the service and deaf staff when they asked for support and they responded to him in kind. One person introduced us to their friend who visited them on the second day of the inspection and the registered manager warmly welcomed them. The registered manager frequently interacted and used their signing skills with people. When one person displayed behaviour that challenged the service they intervened quickly to help staff diffuse the situation. The registered manager told us their signing skills will be assessed in July 2017 and as part of their personal development and planned to undertake BSL level 2.

The provider sought staff's opinion through the use of team meetings and used these meetings to keep staff updated about any organisational changes. Displayed on the office noticeboard staff had written down their ideas about how they wanted to shape the service in the next five years, examples included a special care

home for older deaf people. The staff said they had done this so their ideas would be open for discussion. Staff spoke favourably about the registered manager and said they were committed to making improvements to the service. A staff member said, "We have strong team and a good manager who is available when you need him."

Feedback had been sought by the provider to include people using the service and professionals. The provider used surveys to obtain people's opinions with the help of an advocate to read or interpret the questions presented to them. These showed that some people did not fully understand some of the questions asked. We noted some of the questions did not fully explore the people's answers, for example, where people were satisfied or dissatisfied with the service, the surveys did not ask the reason(s) for this. The registered manager noted this and agreed these should be revised. As part of their placement to obtain a health professional qualification a student had worked at the home for a number of hours and staff had received written compliments about their work, which explained that the staff were very friendly and worked together to provide a good service, and indicated the recruitment of more deaf staff would build a stronger rapport.

After receiving the last CQC inspection report the provider facilitated a workshop with an interpreter to inform people about the findings of the report and the impact and progress the provider had made so far. Discussions were held with people about what was working well and what needed to change. People's thoughts and ideas were noted and their ideas incorporated into the provider's involvement standards process for the current and following year. These actions were then mapped to the 'making it real' (MIR) document that laid out several improvements the provider aimed to drive forward. The document was also produced in an easy read format and included several actions such as the organisation to film more information in various formats including BSL, people being involved in interviewing staff and 'meet and eat' events about staying safe. A staff member said, "We worked really hard as a team to get it back, together we have achieved, we are smiling a lot more, we have put lots of things together, it is a work in progress, it has motivated me, stimulated my interest, it will come to the point we will become excellent rather than good."