Central Bedfordshire Council

Linsell House

Inspection report

Ridgeway Avenue
Dunstable
Bedfordshire
LU5 4QT

Tel: 01582699438
Website: www.centralbedfordshire.gov.uk

Date of inspection visit:
13 April 2016
14 April 2016

Date of publication:
18 August 2016

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 13 and 14 April 2016 and was unannounced. During our last inspection in April 2014 we found that the provider was meeting the legal requirements in the areas that we looked at.

Linsell House provides accommodation and support to up to 12 people with profound and multiple learning disabilities (PMLD) and provides a respite service to up to four people at a time. There are 40 people who use this service. At the time of the inspection there were 12 people living at the home and four people being provided with respite care.

The service has a registered manager. 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.

Linsell House is a purpose built single storey home arranged over three units connected to the management offices by corridors that allow people free access to the whole of the building and the enclosed garden, in which people are supported to grow fruit and flowers during the summer months. The corridors were decorated to reflect the changing seasons and provide a stimulus for people throughout the year. The building had undergone some refurbishment to ensure that the facilities provided best met the complex needs of the people who lived there or used the respite service. This had included refurbishment of the bathrooms to include custom built Jacuzzi baths that enabled all the people to have an enjoyable and relaxing bathing experience. The rooms of the people who lived at the home had been furnished to reflect their tastes and included sensory equipment that they could operate themselves when spending time in their beds. The rooms in which people that used the respite service stayed had plain walls that were decorated with pictures and items in a way to suit the individual who was to occupy it, even if this was for only one or two nights. This gave people with complex needs a familiar setting in which they felt comfortable away from their family carers.

People were protected by exceptional systems to recognise and report suspected abuse. There were easy to use telephones in a prominent position on each of the three units connected directly to the local safeguarding team and the registered manager with easy to read instructions on how to use them in plain sight. Staff had completed training in the protection of adults and had an excellent understanding of their roles and responsibilities in this. There were very detailed, person centred risk management plans for each person who used the service, including personalised assessments for each and every activity that they undertook and support strategies to reduce the risk of harm to them or other people. When new ways of working were to be introduced these were discussed with the local safeguarding team and approval for the policies and processes sought where this was appropriate before the new way of working was implemented.

The registered manager, the management team and the staff were passionate about providing people with

support that would enable them to lead happy and fulfilling lives. They sought to provide a service that reflected the most up to date research in the support and development of people with PMLD and a specific diagnosis. This had included the introduction of intensive interaction to support people and increase their communication skills. Intensive Interaction supported staff to engage in quality interaction with people on a one to one basis, using their preferred method of communication. Staff worked with other services that supported people, such as day centres and family carers to ensure that people received continuity in this approach to their support. Relatives of people who had taken part in the pilot scheme told us of the improvement they had seen in people's communication skills; they had learned how to take turns and were developing listening skills. This had considerably enhanced people's life experiences.

The whole staff team were committed to providing systems, including new technology that would enhance people's lives. We saw evidence of how this had been achieved in a number of areas, such as touch telephones on each unit that connected directly to the registered manager, the walkie-talkie phones used to support people and the custom built baths in the residential units that had light displays. These had enhanced people's independence and experiences.

People were very happy living at the home and using the respite service. They had formed very close relationships with other people and the staff who supported them. Staff viewed them as members of their extended family. The service operated a key worker system where one member of staff was responsible for working with an individual to develop and review their care and support plans in both the residential and respite services. People knew who their key worker was and had formed very close bonds with them. Key workers identified people's interests and explored activities that could support them with these and others that would expand their life experiences. These had including flying an aircraft, attending concerts at the Royal Albert Hall in London, riding in a horse and cart and attending an exhibition of Elvis memorabilia in Greenwich. People had a full calendar of activities available to them and friends and family were encouraged to participate in events to increase the family feeling. People who had moved on from the service were invited to and attended many of the social events that were arranged to maintain their relationships with the people who used the service. The registered manager used these events as an opportunity to talk with families and obtain informal feedback on the service and how it could be improved. This supplemented the regular methods of obtaining feedback such as annual surveys and meetings. People were also encouraged to spend time talking with staff in the office when they were able to express their views and make comments about the service provided. The registered manager operated an open door policy and people and relatives stopped to talk with them The registered manager knew every relative of people who used the service by name. It was clear that the registered manager listened to the feedback received from people and relatives and, wherever possible, had implemented improvements that had been requested.

Linsell House, in partnership with a community based company had set up a peer advocacy group to support people who lived there and to speak up for them. Young people with a learning disability had been recruited and trained at Linsell House by the registered manager to become advocates for the people who used the service. They visited the service at least monthly and provided feedback to the registered manager on people's views and experiences. The peer advocates had provided insight and understanding of the people they supported which the staff had used to improve their understanding of the people they cared for.

Staff had an excellent understanding of the complex needs of the people who lived at the home and those who used the respite services. They had received specialised training to meet people's physical needs, such as stoma care. They had also received training to support people's mental and emotional needs and to understand the challenges that they and the families who support them faced. Individual members of staff

had been nominated as champions to ensure that people with a specific diagnosis received care and support that reflected the most up to date research and recommendations.

Staff used various ways to communicate with people, such as talking schedules, symbol cards and sign language as well as easy to read documents and objects of reference. They had developed ways of interacting with people that they shared with others that supported them to ensure continuity in the way that support was given to them when they were away from the service. Staff were passionate about the rights of people to be consulted and to make their own choices. This was reflected in the way the care and support plans were written and the way in which staff supported and encouraged people to make decisions when delivering care and support.

Staff were very clear about their roles and responsibilities toward the people they supported to enable them to maintain the maximum possible level of independence, choice and control. As well as following the provider's visions and values the staff had introduced their own charter to further endorse respect for people and colleagues. As the staff were aware of almost every aspect of people's lives, people and their relatives were provided with information about the staff who cared for them so that they were in a more equal position.

The service had introduced a quality assurance system that reflected methods used by CQC in our inspections. These had included the use of observations based on CQC's short observational framework for inspections and quality audits that reflected across the five areas of safe, effective, caring, responsive and well led. In addition the service had appointed a number of champions to ensure that the most up to date and best practice was followed in the delivery of care and support for people with PMLD. There was a CQC champion who reviewed reports published by CQC on a weekly basis to identify areas of excellence that could be incorporated into the service delivery.

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 very safe.

People and their relatives felt that they were very safe when they used the service.

There were exceptional systems in place for people to access the safeguarding team and the registered manager if they considered that there was a risk of abuse. .

Policies had been developed and approved by the local authority safeguarding team before methods of support that included touching and close interactions with people were introduced.

Comprehensive risk assessments were in place for every activity and were continually reviewed and managed in a way which enabled people to be as independent as possible.

Recruitment policies were in place and focussed on ensuring that only staff that could meet the needs of the people that used the service were employed

Is the service effective?

Good

The service was very effective.

People received care and support that was based on their needs and wishes. This promoted their wellbeing and encouraged them to enjoy a stimulating and meaningful life.

Staff had good access to training and the management team used various ways of training staff to assist them in providing a high standard of care to people.

Agency staff underwent a thorough induction and received training in the home's policies and procedures before they supported people who used the service.

Staff were encouraged to develop creative ways of seeking people's views and encouraging communication. Staff supported people with their communication needs and had increased people's ability to communicate with staff and

relatives. Where people communicated in other ways such as by Makaton and their own individual signs to express themselves, staff were trained in and were familiar with these.
Is the service caring?

Is the service caring?

Good

The service was caring. It provided caring support.

We observed positive interactions from staff and people's enjoyment in response to this.

Relatives were very pleased with the care and support their family member received. They said that staff were passionate about the care they provided and their family members were treated with kindness, respect and dignity.

The service had developed a system of peer advocacy in conjunction with a local college and peer advocates visited the service at least monthly to support people.

Staff accompanied and stayed with people during any hospital admissions

Is the service responsive?

Good

The service was responsive. It was very good at responding to people's needs and preferences.

People received care that was very flexible and responsive to their individual needs and preferences. Staff were creative in enabling people to live as full a life as possible.

Care plans were personalised and people and their families had been involved in developing these. Staff used innovative and individualised ways of involving people so that they were consulted, empowered, listened to and valued.

The arrangements for social activities were inventive and met people's individual preferences.

Is the service well-led?

Good

The service was well-led. The management and leadership of the service was good.

People told us the registered manager and the unit managers were approachable and available and willing to listen to them.

The registered manager and unit managers were passionate and dedicated to providing an high quality service to people.

The staff team worked in partnership with other organisations at a local and national level to make sure they were following up to the minute practice and providing a high quality service.

The registered manager had a clear vision and researched and introduced systems to improve people's quality of life. They had been creative in the use of staff resources, technology and person centred planning to support people's well-being.

There were procedures in place to monitor the quality of the service. Any issues found were quickly acted upon.

Linsell 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.

This inspection took place on 13 and 14 April 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with three people and six relatives of people who live at the home or use the respite service, a visiting healthcare professional, three support workers, three unit managers and the registered manager. We observed the interactions between members of staff and people who used the service. We reviewed the care records and risk assessments for two people who live at the home and three people who used the respite service. We checked medicines administration records and looked at staff recruitment and training records. We also reviewed information on how the quality of the service was monitored and managed.

Following the inspection we spoke with two health care professionals and reviewed additional supporting documents provided by the registered manager.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us that they felt safe. One person told us, "I feel safe. All the people look after me." A relative told us, "I don't worry at all when he is here."
Another relative said, "Safe? Definitely. There is always someone on at night. On two occasions [relative] has been taken to hospital at night after staff found them to be poorly." Another relative told us, "He is safe. The staff know him and what he is like."

People were protected by exceptional systems to recognise and report suspected abuse. Posters were displayed around the building that explained to people what could be considered as abuse and what action should be taken if necessary. The information was in both written and pictorial format so that people could understand it and acted as prompts that kept the profile of safeguarding visible to staff and people. There were easy to use telephones in a prominent position on each of the three units. These had large numbers and buttons and were readily accessible by staff, people who lived on the unit and any friends or relatives that visited them. Three buttons on the telephones had been pre-set to automatically dial the local authority safeguarding team, the registered manager or the CQC when pressed. These buttons had photos attached which told people which service they would contact when they pressed them. Next to each of the telephones was a poster that encouraged people, relatives and staff to use them should they have any concerns about people's safety. The registered manager told us that they contacted the safeguarding team regularly to see how many times people and staff had used the telephones to call them. The manager told us that the telephones had been used approximately once every two to three months to either raise concerns or ask for advice.

Staff had completed training in the protection of adults and had an excellent understanding of their roles and responsibilities. They described the types of abuse they might come across and how they would raise concerns to senior staff and the safeguarding lead. One member of staff said, "We had safeguarding training in June and I did my on-line training after that. We have safeguarding sessions and [have to answer] questions [on it] every couple of months. I would report any suspicions immediately to my supervisor and manager and fill in [a referral] to the safeguarding team." The registered manager told us that staff competence and understanding of the safeguarding processes was tested every year in exercises using different scenarios. Another member of staff told us they would recognise the signs when someone was worried as, "I work with them every day and have got to know them well."

Policies were up to date and included ones for safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Staff told us that they were aware of the whistleblowing procedures and would not hesitate to use them if they saw any incorrect practice. One member of staff said, "If I see someone mistreated I can raise the alert and I know the different forms of abuse."

There were person centred risk management plans for each person who used the service, including personalised assessments for each and every activity that they undertook. The risk assessment identified who the hazard posed a risk to, what the risk was and why it was a risk. It also detailed what could happen

and what had happened in the past. For example every step of the process for one person to be taken to hospital in Cambridge for day surgery had been risk assessed and steps put in place to mitigate the risk. As the journey required a very early start the risk of staff being tired was reduced by arranging for them to stay at the home the night before. An alternative option had been for the person to be admitted to the hospital the night before their operation but this would have been very traumatic for them. The risk of harm was reduced by travelling on the same day. The personal risk assessments detailed why taking some risk was important to the person, and the actions that were being taken to minimise the risk. For example, the manual handling risk assessments were pictorial and included photographs of the actual equipment and slings used for each person. This made them easy to read and follow for staff and reduced the risk of inappropriate equipment being used to transfer people.

People or their relatives were involved in determining the level of risk that was acceptable to them. For example two people liked to go to a local nightclub on a monthly basis as it allowed them to dance and enjoy the social atmosphere at the club. The risks that they could be exposed to during these outings had been identified and actions identified to minimise them. For people who might display behaviour that could have a negative effect on others, there were support strategies in place to reduce the occurrence of the behaviour and one to be used to support the person to become calm again. Staff told us that these strategies were effective in keeping the person, other people in the home and the staff safe.

The registered manager had devised a flow chart and risk assessment for the introduction of intensive interaction with people. This form of interaction required close proximity with people and the use of touch as a form of communication. One of the unit managers had developed local policies to protect people and members of staff when they were conducting such interaction with people. These had been referred to the local safeguarding team who had approved the policies which enabled the staff to work safely with people in this way. This was an example of how the risks of any new ways of working were identified and the risk of harm to people and staff minimised.

There were general risk assessments completed for any activities that were to be carried out within the home or any other risks that had been identified. One person who lived at the home had been diagnosed with a potentially infectious illness the weekend before our inspection. The registered manager had completed a risk assessment to identify the level of risk to other people who had come into contact with the person. Future activities within the home included contact with various animals and risk assessments had been completed as to the possible harm that people could be exposed to and how this could be minimised. Records showed that the registered manager had carried out assessments to identify and address any risks posed to people by the environment. These included risk assessments of the kitchens on each unit and for when the weather was hot. There were also plans in place for the continued operation of the service in an emergency. Each person had a personal emergency evacuation plan should an emergency occur. These were reviewed regularly to ensure that they reflected the support people would need to leave the building.

One member of staff told us that they were responsible for providing fire training to all staff and regularly tested staff's knowledge on the subject by way of questionnaires. They also held unannounced fire drills every two months so that people and staff were reminded of what to do in the event of an emergency. They had held a simulated night time drill in March 2016 and people and staff had been evacuated within four minutes.

Accidents and incidents were recorded and the registered manager analysed the causes regularly to identify ways in which similar accidents or incidents could be prevented. Any learning from the analysis of the incidents was shared with members of staff at supervisions and team meetings.

There were enough staff to support people safely. Staffing levels had been determined by the needs of the people who used the service and the levels of support that had been identified within their needs assessments. The normal staffing level was one support worker to two people but some people required one to one support and others required additional support at certain times, such as when they were receiving personal care. The registered manager told us that staffing levels were flexible and depended upon what people needed. We saw that staff were not rushed and had time to sit and talk with people.

The provider had a robust recruitment policy. This included the making of relevant checks with the Disclosure and Barring Service (DBS) to ensure that the applicant was suitable to work in the service, health questionnaires to ensure that applicants were mentally and physically fit for the role applied for and the follow up of employment references. Applicants were asked for their full employment history on the application form. This assisted the provider to determine whether the applicant was suitable for the role for which they had been considered. When agency staff were used before they started their first shift at the home they met with the member of staff who was nominated as the 'agency champion', given a written introduction to the home, its policies and procedures and completed in-house training. This enabled the registered manager to be confident that the agency staff had the skills needed to care for people.

Staff told us that they received regular training on the administration of medicines and the registered manager had appointed a 'medicines champion'. They provided staff with support with medicines administration and information about any changes that had been made to an individuals prescription. Medicines were stored appropriately within a locked cupboard in a kitchen in each unit of the home. Medicines were administered by two permanent members of staff who had completed their training and had been assessed as competent to administer them. Agency staff were not allowed to administer medicines. Staff told us that their competency to administer medicines was checked annually. We looked at the medicine administration records (MAR) for two people and found that these had been completed correctly, with no unexplained gaps. As well as a photograph of the individual each MAR included photographs of each of the medicines the person took. This provided added assurance to the members of staff who administered the medicines and to the individual that they had been given their appropriate medicine. Protocols were in place for people to receive medicines that had been prescribed on an 'as needed' basis (PRN). We saw that there were also protocols in place for ordering medicines and for the return and disposal of any unused or unwanted medicines.

We were advised of an incident in which staff had identified that symptoms of illness displayed by one person could have been caused by the pain relieving medicine that they had been prescribed. Staff discussed this with the GP who agreed that the medicine should be discontinued and the person's pain monitored and managed by an alternative regime. This showed that staff were knowledgeable about the medicines people had been prescribed, were aware of any adverse effects these could have on people and monitored them accordingly.

Good

Is the service effective?

Our findings

People and their relatives told us that the staff definitely had the skills needed to support them effectively. One relative said, "I think they are very good." Another relative told us, "My [relative] was in hospital in 2014 and now has a stoma. They got people in to train all the staff. Whoever looks after [relative] knows what to do." Another relative said, "I think the staff are well trained. They all know [relative] and all seem to know what to do for [them]." A healthcare professional told us that the staff were very skilled and always did what was asked of them.

Staff received a full induction before they worked on their own with people and on-going training to improve their skills. One member of staff told us, "During my induction I did all the basic training such as manual handling. I was shadowing (watching an experienced employee) for three weeks, one week in each of the three units. I was shadowing different people. I read the policies and looked at the support plans for everybody. When I was shadowing I was able to get to know the clients and their likes and dislikes. This gave me a good idea on how to support them. Members of staff provided by an agency also received an induction before they started working at the home with a full induction programme, as had the transport staff and the musician who attended the service on a weekly basis. manual handling training was delivered to all staff, including those provided through an agency, by the registered manager. they also provided training to staff from other services, such as the day care centres, that provided support to people who lived at the home. This demonstrated that the service ensured that everybody who supported the people who used the service had the necessary skills to do so effectively and safely.

Prior to the introduction of intensive interaction, relatives were made aware of the initiative and the ways in which interactions would take place. Following meetings with the support teams at which the possible benefits of the interventions were explained relatives agreed that it would be in people's best interests to take part in the pilot. . Intensive Interaction supported staff to engage in quality interaction with people on a one to one basis, using their preferred method of communication. Staff allowed the individual to take the lead and acknowledged that everything they did or said was important and a form of communication. The registered manager arranged for five staff from the home and day centre to attend a five day course, run by a leading exponent of the method. Having staff from both the service and the day centre that people attended trained meant that people received continuity of care between the home and their day centre. It would have been confusing for them if intensive interaction only happened within the service and would have reduced the effectiveness of the interaction. Each episode of intensive interaction was documented and evaluated to monitor any progress made. Staff found that some people with very limited methods of communication had not only engaged more but had also sustained 'eye contact' during an activity and had often taken the lead. A relative of one of the people supported in this way told us that the individual had become more communicative with them since they had participated in the pilot. This demonstrated that the service had assisted the person to connect with other people and increase the quality of their life.

All staff had also received training in the 'Involve Me' project which looked at creative approaches to support. This linked with the intensive interactions pilot and looked for ways in which personalisation of support could be improved. It included looking at alternative methods of communication, such as talking

schedules and sign language and providing activities that were based on the individual's known likes or which would have a significant impact on their quality of life. This enabled the service to provide more personalised care to the individuals they supported.

The registered manager had also appointed in house champions to educate staff about person specific diagnosis such as Wolf Syndrome, and to enable staff to keep abreast of best practice in supporting people with these conditions. The service also worked in partnership with other healthcare professionals to ensure that staff were fully trained and updated in areas such as gastrostomy care, pressure care, dressings and colostomy care. Staff told us that they had regular refresher training on areas considered important by the provider, such as health and safety, food hygiene, infection control and medicines administration. One member of staff told us, "If we don't check whether we have training due the line manager checks when we have supervision. If we want more training that is not on [the provider's] system we tell the manager. I want to do training for signing and we are looking into it." They went on to tell us, "Training gives us all the information and guidelines to do the job in the best way possible – everything that is essential. All of it is relevant to our job. We have recently been given a different topic every month to look at and are tested on it." The registered manager told us that the monthly topic was a programme of in-house learning and development that was run in addition to the mandatory learning and had been introduced to enable them to be confident that staff had completed and understood the required training. It also acted as a refresher for staff in the selected topic.

Staff received regular supervision with the unit manager during which they could talk about anything that concerned them, their training and the people they supported. Managers within the service were working with the Institute of Leadership and Management to gain accreditation of a management qualification following the service's bespoke management development programme.

Staff had received training on the requirements of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People were asked for their consent before support was given. One member of staff told us, "We know the people we support and always speak with them and tell them why we do what we do. I use body language and their expressions to tell me that they are okay with it. If they show signs that they don't like or want the support I stop." We observed that staff always spoke with people and continually encouraged them to receive support. People's care records included a communication passport and information for staff on the way people behaved if they needed support. For example one record showed that if the person was upset their facial expression would change, they would frown or shake their head. They would also touch their forehead if they were in pain.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest following meetings at which they, their relatives and their support teams had been present. The service has supported the provider in the development of a new care plan format that incorporates MCA and DOLS, in essence, becoming a Best Interest Care Plan. This will be used as a benchmark across Central Bedfordshire Council in residential services where people's capacity may be compromised.

People had a variety of dietary needs. A relative told us, "[Name] has to have all their food blended as [they] cannot chew. They just have normal food blended and eat everything. I have no concerns." A relative told us, "I put together a menu of food that [Name] likes but if [they] don't want to eat one meal they will give [them] something different." A unit manager had been in touch with the healthcare professionals and arranged for one person who received all their food and fluid by way of a percutaneous endoscopic gastrostomy (PEG) tube to receive their nutrition overnight as this would be less restrictive for their day time activities. Some people required soft or pureed food. The service had recently introduced food moulds that were used to shape mashed food into the original shape of the item, such as a fish mould. This enhanced the presentation and assisted people to identify the food they were offered. Where people were more independent and could be involved in assisting with food and drink preparation, the doors of cupboards and refrigerators had pictures showing the contents of each to help them in their task.

Special diets were provided for people with cultural or religious requirements. One member of staff described how family members were involved to determine what diet would satisfy the requirements of an individual's culture and religion whilst enabling them to maintain a healthy weight. Menu boards were used to enable people to choose what they would like to eat. People tasted different foods and drinks at special meetings and their reactions to them were monitored. In addition food feedback questionnaires were completed after every meal and used to shape menus for individuals. If people liked a particular food or drink, or disliked a particular choice, their food and nutrition support plan was updated to reflect this. We saw that at one meeting people had tasted different kinds of tea and their support plans had been updated following this to record their likes and dislikes

People's weight was monitored on a weekly basis and staff involved other healthcare professionals, such as Speech and Language Therapists (SALT) and dietitians, should there be any concerns about people's weight. There were small plates of food and drinks in various places around one of the units. The plates contained the favourite foods of one person who lived in the unit and were left out to encourage them to eat. Staff encouraged the person to try the foods every time they went near any of the plates.

People were supported to maintain their health and well-being. When people had been admitted to hospital a member of staff always accompanied them and stayed with them during their stay. One relative told us that when their relative had been admitted to hospital, "[The registered manager] came up; staff came up and sat with [name], gave them lunch and came up again in the evening." When a person needed a minor operation at a hospital in Cambridge the unit manager liaised directly with the hospital consultant to enable the person to only attend the hospital on the day of their operation. The person and the two support workers had to leave the home at 4.30 am to achieve this. As the person also needed to undergo a blood test, which would be a traumatic procedure for them, the unit manager was able to arrange that the blood was taken whilst the person was undergoing the operation. The service also worked with the Health Facilitation Team. For example, support with blood tests for one person as sedation in their home environment saved them from having to go to hospital where they would not have coped well in the environment.

Another of the unit manager's had identified that people who lived at the home were at high risk of cardiac arrest due to their physical conditions. They worked with the East of England Ambulance Service to obtain a defibrillator with funding from the NHS and for all the staff within the home to be trained to use this. This meant that people could be treated immediately by competent staff whilst waiting for the emergency services to arrive.

Records showed that people were also supported to attend appointments with other healthcare professionals, including dentists, opticians, district nurses, mental health professionals, occupational

therapists and chiropodists. One relative told us, "The keyworker lets me know of any appointments at the hospital or anything." The unit manager for the respite service told us that they arranged for a chiropodist to attend the home when a person who used the respite service was staying there as their family carer was unable to arrange the attention they needed for them when they were at home. A GP who was visiting the home told us that staff did not hesitate to contact them should they feel that a person was unwell.

Linsell House was purpose built for people with a learning disability about 20 years ago and had undergone various adaptations and refurbishments which had enhanced the environment for the people who lived there. The three units and the offices were connected by corridors built around a courtyard garden and had well maintained gardens. The walls of the units and corridors were covered in decorations and photographs of people on activities to remind them of things they had enjoyed. The walls also included posters of items used as 'objects of reference' for people to identify where they were, for example a kitchen area had a wooden spoon hanging by the entrance, and a bathroom had a rubber plug. One corridor was set up with flower beds and decorative paper trees, flowers and butterflies so that people could imagine themselves to be outside even when the weather was poor. Staff told us that the theme for this corridor changed with the seasons. We saw photographs of when it had been decorated as a winter wonderland. The corridors were wide and people were able to move around them freely in wheelchairs. Some people had electric wheelchairs which they used to move all around the home.

At the time of our inspection the sensory room, which was used by people to relax or spend time alone with their family members, was in the process of being updated. People's rooms were large enough to provide for wheelchairs and other equipment and had been decorated to the person's choice. For people who spent a lot of time in their beds, their rooms had been equipped with lights and music which they were able to control from their bed. There were custom built baths in the two residential units which were especially designed to provide for the bathing needs of all the people on the units. The baths had Jacuzzi jets that relaxed people and lights that changed colour and contributed to the relaxing experience. Staff told us that people were happier to receive personal care following the installation of the new baths.

Good

Is the service caring?

Our findings

People and relatives told us that staff were very kind and compassionate. One person said, "The staff are nice." A relative said, "They are brilliant …very, very caring." Another relative told us, "[Name] is extremely happy when [they are] here. The staff are very friendly. Even the cleaners are really friendly and say 'Bye [name] – see you soon.' I can' fault it." Another relative told us, "I just accept that whilst [name] is in here they will look after [them] like I do."

Interaction between staff and people was caring and supportive. A relative told us, "[Name] laughs and is very happy [when they are here.]" Another relative said, "[Name] is very happy. It is just like a hotel. They do go the extra mile." They went on to say, "They are not just working for a job. They are here because they want to be." One member of staff told us, "This place is amazing. It is happy and lively. Everyone gets on and it is a lovely, lovely place to be. You can see in the client's faces that they are very happy." A healthcare professional told us that the staff knew how to support people appropriately and actively promoted their independence.

Staff worked continually to show people that they cared for them. One person told us how their key worker had supported them when they were a bridesmaid at their brother's wedding. The key worker went with them to every dress fitting and arranged for a professional to do their hair and make-up. The key worker stayed with them throughout the day and supported them to attend the reception in the evening. The person was thrilled with the support that they had been given and proudly showed us photographs of them in their dress. Staff had also organised a special birthday party for them together with a member of their family and enabled all of the people who lived at the home to attend. Staff went in on their days off to support people at the party. The person showed us the scrapbook that staff had put together to remind them of the day. This included the cards they had received and photographs that staff had taken at the party.

People and their relatives were involved in decisions about how their support was delivered. Many of the people, particularly the people who used the respite service, had very specific routines which staff were required to follow. This made the people feel more settled and at home, particularly when arriving at the home or at bedtime. These routines were documented within their support plans in great detail to ensure that staff could follow them exactly. For example, the parent of one person had recorded a good night message which staff played to them before they finally settled for the night. Another person had a set routine which involved them sitting and having a cup of tea before they went to their room, which had been set up by staff in a very specific way, following their arrival at the home. We observed staff asking people what they wanted to do, what drink they wanted and whether they wanted a snack. One person was feeling unwell and a member of staff was observed to be gently rubbing their chest to relieve their symptoms. The person was asked whether they wanted to remain where they were or would prefer to return to their bed where they would be more comfortable. The person chose to stay where they were. Another person wanted to listen to music and staff supported them to choose which music album they wanted to play. A person who was having a one to one session with the musician wanted to go out into the garden instead of continuing with the music session. The musician took them into the garden but returned for their guitar

when the person changed their mind and indicated that they wanted to play the music in the garden.

People and their relatives told us that staff showed respect for the people they supported. A relative told us, "Staff talk to [relative]. The come down to [their] level and talk to [them] appropriately, as an adult not a child." We saw that the staff spoke with people in a gentle, respectful way and used the name they preferred to be known by when speaking with them. They used gentle encouragement to prompt them to do things, such as sit at a table for a meal or join in an activity. People's privacy was maintained and staff knocked on doors and waited to be invited in. One member of staff told us, "I always knock on the door and when I go in I am in constant communication with them. [During] personal care I ensure that they are covered and the door is closed. I communicate with them." They went on to say, "Sometimes people want to be in their room and it is about respecting their choice and giving them 'alone time'."

Staff were passionate about promoting people's dignity. Every member of staff had been trained and had signed up as a 'Dignity Champion'. One of the unit managers had completed a quality audit of the whole service that had focussed on dignity and respect in March 2016. This had identified that people's privacy and dignity were maintained. One example of this was that laundry staff had left a person's clothing outside their room as the person had left the home to attend a day centre. They could not, therefore, give their permission for staff to enter their room.

Staff told us of ways in which people's confidentiality was maintained and said that information about people would only be shared with other people who had the right to know it. One member of staff told us, "We don't discuss anything about within the home outside of the home." Shift handovers were conducted in the staff room with the door closed. This enabled sensitive information to be handed over on a need to know basis with no risk that it could be overheard by other people who used the service or their friends or relatives.

People were able to access a local advocacy service to speak on their behalf if this was required. However, the registered manager had been involved in a project to look at creative approaches to providing support for people with profound intellectual and multiple disabilities (PMLD). They had worked with a local college to establish a pilot peer advocacy service. In this context peer advocacy is where one person with a learning disability advocates for another. The registered manager and the college identified four young people who were suited to becoming a peer advocate and developed a training course for them at the home. They were matched with the people who lived at the home and who used the respite service. They worked with these people to develop relationships and understanding that enabled them to speak on their behalf. In addition the peer advocates carried out announced and unannounced visits to the home and reported on their findings to the registered manager. At one visit a peer advocate noticed that one person frequently stuck their tongue out and asked why this was. It was something that staff had not considered when they supported the person, and they carried out observations to identify the mood of the person and the activity they were completing at the time. This gave the staff who supported that person further insight into what made them happy.

There were information posters around the home in easy read format that covered a range of topics. Each member of staff had completed a one page profile of themselves which was displayed in the corridors of the home. The registered manager explained that this initiative had been agreed as staff knew everything about the people they cared for. It was thought only fair that people, and their relatives, should know something about the staff that supported them. There were information posters by telephones that explained in easy to read format how people could use these. People had posters in their rooms that reminded them how to use the equipment, such as the call buttons. In addition there were special boards to show people who used the respite service how many nights they would be there before they went home. People also had 'mood

boards' that they used to tell staff how they felt and 'now and next' boards that explained to them in easy read format of their daily schedules. A picture exchange communication system, which sequenced events for people who used the respite service, increased their daily structure and the sense of wellbeing when in unfamiliar surroundings.

There were also posters advising people what to do if they were worried or concerned. Information about the home had been updated in 2015 and people had been given a copy of the 'Statement of Purpose' or 'Service User Guide' which was in easy read format. One of the unit managers told us that they produced all the information that people needed in easy to read format. One of the unit managers showed us a 'talking schedule' that was used by people in the respite unit. This was a hand-held device with picture buttons that they pressed and a pre-programmed voice would tell them what to do. This had been found to promote people's independence.
Relatives said that they were always given information about people when they rang and were confident that staff would contact them if they needed to. One relative said, "When I ring up to enquire how [relative] is they always give me the information. If someone answers who does not work on [relative's] unit they will get someone on the unit to ring me back and they always do." Each person had a communication book in which staff wrote information about the person that could be shared with other organisations and people that supported them, such as family members.

Relatives told us that they could visit people at the home whenever they wanted to. One relative said, "I can come in at any time. I can walk around the home. They have nothing to hide. Staff let you in and you can walk down any corridor." The registered manager told us that Wi-Fi was accessible in all units and each unit had a lap top and an IPad that people used to maintain contact with friends and family. People were able to have visual as well as verbal contact with their friends and family and also access via email. This was especially useful for people who had limited verbal communication.

Some people who lived at the home had lost contact with their family members and as a result had been fairly isolated. However, one member of staff had spent considerable time and effort to find the family members of one of the people who lived at the home who it had been thought had no family apart from one cousin. The member of staff had found a further two cousins, who were now in touch with the individual and visited them on a regular basis. This had made the person very happy. The member of staff had worked hard to involve these cousins in the person's life and they were all working together on a family tree for them, including family pictures of as they has very little in the way of family memorabilia. This had provided essential information for the person and had given the staff who supported them valuable insight into their life. Staff had also found and contacted relatives of another person who was thought to have had no family. The staff traced a cousin and an uncle who have both visited the person and remain in regular contact. Staff also managed to obtain a painting that had been completed by the person's late father which they framed and is now by the person's bed.

In addition to caring for people whilst they lived at the home, staff told us that they considered the people who used the service to be part of their extended family. One unit manager had continued to provide care for a person who had been admitted to hospital and had unexpectedly died a short while later. The person had lived at the home for over 20 years and the unit manager had been with them when they died. Family members had been contacted but requested that the management at the home made all the necessary arrangements, including dealing with their estate. The unit manager spent a year resolving issues with the person's estate before they were able to pass the monies onto the family members. Staff also supported one person with their transition to live in the community. This had included rallying round to get them clothes and furniture and keeping in touch with their family and the community. Staff remained in contact with them and go to their birthday celebrations. They were invited to the home and to any events held at the

home so they can keep the relationships they made with the people who lived there.

Good

Is the service responsive?

Our findings

People had complex support needs which had been assessed before they moved into the home or accepted for the respite service. People were usually introduced to the service gradually, first going for tea on a regular basis until they felt comfortable at the service, and then staying overnight. One relative told us that their relative had used the respite service for many months at just one night at a time. They would, however, be staying for two nights at their next visit as the relative and staff thought that they were ready to do this.

The unit manager told us that respite service was usually arranged on a three monthly basis but special arrangements could be made for bookings up to a year in advance so that relatives could plan holidays and other commitments. Special arrangements could also be made in case of a family emergency. The registered manager told us of one family member who had an accident and injured their back. Their relative was admitted to the respite service whilst they recovered. The respite service had also admitted people when families have had building works carried out, needed to attend funerals, at Christmas time so family carers could go shopping or so they could take other children on holiday. This was in addition to their normal respite packages. However, the families were not charged for the additional time people spent in the respite service.

People and their families were involved in deciding the level of support they needed and the plans that were put in place to provide this. Each time a person used the respite service their needs were assessed. One relative told us, "I have paperwork to fill in before [relative] comes. I have to give details of [their] medicines, if it's changed. I have to fill in about anything that has changed or I think they might have an issue with."

We saw that people's support plans were detailed, included relevant information necessary to support them appropriately and reflected their wishes. Information from people's relatives and others who knew them well had been included when the plans were developed. One relative told us, "I asked if they could get [name] up walking. When I have phoned up I have been told that they were walking around. The staff are very good and always listen to what we say." Another relative said, "They are excellent. The keyworker always rings up and keeps me in touch with what is going on." In addition to the full support plans there were 'Alert Pages' for each person that used the service. These were bullet style detailed information for each service user and all staff including agency staff were required to read and sign these. We saw evidence that support plans had been regularly reviewed by people, staff and relatives. A relative told us, "I have reviewed the care plans. I have to sign at the end."

Each person had been assigned a key worker who was responsible for reviewing the person's support needs and agreeing the goals they would work towards. One person told us that they wished to live more independently and have their own flat. Their key worker and the registered manager told us that they had arranged for assessments to be made as to the individuals' understanding of what this would mean. They were also making enquiries of the availability of suitable schemes that could provide the support the person needed. A support worker told us, "People change all the time. We're always learning and have to keep support plans updated. Care reviews are annual. We work on their objectives during the year. [Name] had an objective of going to hydrotherapy last year. We achieved it and they now go on alternate weeks." One key

worker had studied the religion of the person they supported and supported them to wear traditional dress and visit their place of worship. The key worker had also supported them to decorate their bedroom to reflect their spirituality, culture and diversity.

Some staff had worked at the service for many years and had known the people who lived there and had an active role in their lives during this time. The knowledge and information they have gained about the people who lived at the home during this time was invaluable as these staff had committed their lives also to ensuring the best possible outcomes for the people they supported.

We saw that people's plans were reviewed to ensure that the care provided continued to best meet their needs. For example, one support plan contained a protocol for managing the assisted technology used to help them live independently. This included door alarms, intercom, the emergency call system, a pager that sounded automatically if an alarm was triggered and walkie- talkie radios for use when the person was in the garden or grounds of the home. Another support plan contained detailed information on how the person needed to be assisted with stoma care. Staff told us that as a key worker they would check on people's well-being and that support plans and risk assessments reflected the care and support needs of the person. They would research with them what activities they would like to do and holidays they wished to take.

People were encouraged to take part in activities to maintain their hobbies, interests, religion and culture. We saw that people were supported to respect festivals connected with their cultures. The home had laid on a special Diwali celebration for a person of Asian origin. Everybody at the home had been encouraged to take part in the celebration. Celebrations had also been arranged for both the Christmas and Easter holidays. One member of staff told us that a person they supported had loved horse riding as a child. They were unable to do this now as they used a wheelchair. However, the member of staff had identified a charity in Hertfordshire which had a horse and carriage that had been adapted so that wheelchair users could ride in the carriage. This had enabled the person to experience pleasure similar to that they had previously when riding a horse.

Some people were especially interested in music and a musician visited the home every Wednesday. They held a communal session in the lounge of one of the residential units and then had one to one sessions with people who were particularly interested in either playing the guitar or singing. We watched as the musician assisted one person to play the guitar whilst they sang their favourite songs. The person was very engaged and appeared to be thoroughly enjoying the session.

Most people attended day centres for part of the week. However there were many activities arranged by the home to support people's interests. Staff at the home looked for ways to stimulate people and make them part of the wider community. They observed people's reactions when watching films and television programmes to identify activities that they might be interested in. In addition each unit had IPads which were used by key workers with people to make choices about their leisure activities. One person told us that staff had taken them to a concert by Cliff Richard at the Albert Hall in London, they were a great fan of his, and to a local theatre for a 60's themed evening of music and entertainment and also went to a disco in Luton on a monthly basis. The person told us that they chose the outings that they wanted to go on in discussions with their key worker. They had their own IPad which they used to search the internet for things they would like to do. Their key worker ensured that they had sufficient money to pay for their outings and staff took photographs of these events which were saved in scrapbooks for individuals so that they could look at them at any time and remember the outing. The person showed us their scrapbook containing photographs and other memorabilia, such as programmes from the Cliff Richard concert. They told us that they looked at these often to remind themselves of what they had done and that this made them feel very

happy.

Another person had a liking for music and in particular that of Elvis Presley. We saw that the unit in which they lived had tributes to Elvis around it, including a clock in the dining area and coasters on the table. There were CD's and DVD's of Elvis concerts that the person played. They were happily dancing to the music during our inspection. The person's key worker told us of the amount of planning that had been required to arrange an outing for the person to attend a recent exhibition of Elvis memorabilia at the O2 Arena in London. When we asked them if they had enjoyed the experience they indicated that they had very much. The key worker also took the person to a disco in Luton on a monthly basis where they were able to dance and share their interest in music with others. This enabled them to socialise with the wider community.

One member of staff told us of the planning and arrangements that had been needed to arrange for two people to go flying in a light aircraft. They had been advised of the possibility of flying and both were really keen. The planning had included a session on a flight simulator so that they could decide whether they wanted to go in the aircraft. Throughout the planning they had both been assured that they could withdraw from the experience at any time but were both very keen to continue. Both told us of how exciting it had been and how much they had had enjoyed the experience. One person told us they had been allowed to assist the pilot with the landing as they had not crashed the aircraft in the simulator. They had found this experience to be very exciting and wanted to do it again.

People were encouraged to choose where they went on holiday. One person told us that they were not going to go on holiday this year as the preferred to have a number of day trips throughout the year, although they were considering going away next year. The registered manager told us that key workers assisted people to choose their holidays by showing them brochures and sites of suitably equipped holiday venues on the internet. Before encouraging people to select a holiday the key worker had ensured that they could afford to pay for one so that they would not be disappointed.

Every month there were special events arranged. Relatives told us that they were invited to these. One relative said, "[Registered manager] has done a remarkable job with the music therapy and everything. It is the parties and tea things they have are so good. It is lovely to see them so happy and so integrated with the rest of the people. They had one over Easter and it was a lovely time. [Name] looked really happy." Another relative said, "I get invited to events and come when I can."

During March the home had organised for an incubator and eggs to be kept in one of the lounge units. Other events planned throughout the year included an indoor animal experience, an outdoor farm, a Latin American day to celebrate the Olympics and Diwali celebrations. Everyday activities included baking bread and gardening. People had grown strawberries in the summer and had made their own jam with some of them. People had baked cakes for the afternoon tea that had been held for friends and families at Easter. This had enabled people to be part of the community and be involved in the wider events that were taking place.

The registered manager told us that the events were used by the management team as an opportunity for parents and family members to chat and ask questions. It allowed people who used the respite service to socialise with people they may have met at the service and their family members to associate with and gain support from each other. Three families had planned a holiday together later in the year whilst their relatives stayed at the respite service. This demonstrated that the service provided support to the families of people who have PMLD as well as the people themselves.

People and relatives told us that they would talk to the staff or the registered manager if they were not

happy about anything. One relative told us, "If I have any issues I ring up. They are very good at getting back to me. "Another relative said, "I made a complaint in 2010 when [registered manager] was first here. I can talk to him about anything." Another relative said, "If I had a complaint I would start with the manager but I have never had any problem." We saw that the provider had an established complaints system in place and leaflets about this were available to people and their relatives.

People and their relatives were asked to comment on their level of satisfaction with the service on an annual basis. One relative told us, "They send me a questionnaire. Communication is 100% better than it was in the past." Of the responses that had been received in the most recent survey from people who used the service, all were totally positive about the service. People had been asked to give the service a star rating out of five. Four people had given a four star rating, five people had given a five star rating and one person had rated the service as six stars. This demonstrated that people were happy with the service they received.

Good

Is the service well-led?

Our findings

People, relatives and staff told us that the registered manager and the unit managers were very supportive and approachable. One person said, "[Unit manager] is nice." A relative told us, "[Registered manager] is very good and a very kind man as well. When I was upset he put his arms around me and gave me a hug." Another relative said, "[Registered manager] is very approachable inside and outside of the home." They went on to say, "[Unit manager] is lovely, very, very good." We saw that the unit managers and the registered manager all knew the names of the relatives of people who lived at the home and who used the respite service. The registered manager greeted each relative by name and spent time talking with them. They told us that people were welcome to spend time in the office and talk with staff and managers there. It was through these talks that the service had identified that one person wished to move into their own flat and steps were being taken to explore the possibility of this happening. This was an example of management listening to and acting on the wishes of people who used the service.

One member of staff told us, "It is a very good team. We all work very well together. [Registered manager] is very approachable and hardworking." Another member of staff told us, "I enjoy working here. I can get to do so much. I can try things I think they might like or make things better for them." They went on to say, "[Registered manager] is pretty good. Very supportive and can go to them if I have concerns or need advice. But [Unit manager] is good. I would go to [Unit manager] first but if it was serious I would go straight to [Registered manager]. "

In 2015 the service was awarded the provider's Team of the Year Award. There had been 13 nominations for the award across the provider's services. In giving the award to Linsell House the committee commented that, "Exceptional service is demonstrated through team working and good practice. Significant results have been achieved over and above the expectations to define in their remit, as a result of a multi-disciplinary team working. They can demonstrate how the skills of all team members have contributed to their success "The service had been audited by the provider's contracts and monitoring team in September 2015 and had received a rating of 'excellent'.

We saw that the registered manager and the unit managers were passionate about making improvements to the lives of the people who used the service and keeping abreast, and in many ways, ahead of the field in the care and support of people with profound and multiple learning disabilities (PMLD). The registered manager and unit managers kept abreast of developments in PMLD and attended training and seminars on new developments within the sector. They had identified champions within the staff team who kept up to date with research into treatment and support for people with a specific diagnosis, such as Dravet Syndrome. This enabled the service to provide support that reflected the most up to date recommendations.

The obvious enthusiasm and passion of the management team had instilled a desire within all the staff to look for innovative ways to support people to achieve their ambitions. Both the registered manager and the unit managers were highly visible on each of the units and led staff by their example. The manager showed us a development plan for the service that they had shared with the provider which showed many initiatives

that they and their team wished to develop. These included using new equipment, such as trampolines, to increase people's mobility, providing even more varied activities that would develop people's skills, such as pottery, increasing links with other professionals and working with other providers to enhance people's experiences.

The service had forged links with a number of organisations within the local community. A local college provided volunteers to develop a sensory garden within the home which included mirrors to reflect the garden for people who used wheelchairs. Other local groups advised of parties and other events that they held so that people from the service could attend these, make friends and to interact with other people. The Salvation Army had supported people at the service for a number of years and provided interactive music sessions on a regular basis. The service also had links the local pubs, theatre, cinema, bowling alley, ice rink and the local bus service. It had hired one of the local pubs so one person could have a 'jamming' session and a local hall for a birthday party.

The development plan also included enabling the staff of the respite service to develop more advanced skills in supporting people with PMLD due to the variety of complex needs of the people who used the service. We saw that some of the initiatives had been supported by the provider and everyone in the staff team was enthusiastic about the new initiatives to improve the experience of the people who lived at the home.

Staff told us that their purpose was, "To provide fulfilling, enriching experiences for the people who live at the home and who use the respite service. To provide everything to make them happy and comfortable." It was felt important by everyone in the home that there was a set of shared values and a vision to work with both for staff already employed and also for new staff recruited so they knew right from the offset how the service worked and what was important in terms of outlook and focus. Staff were asked about their views of the home, what would make it a better place and how they would contribute to this. We saw that the staff had agreed a 'Staff Charter' which set out their own vision and values. These included treating people fairly and with respect, putting honesty and openness at the heart of all their relationships. Other areas included teamwork, opportunities for personal growth, courage, compassion, responsibility and co-operation.

The registered manager told us that they used observations based on Care Quality Commission short observational framework for inspections. They used these observations to pinpoint practice, both good and bad which was shared with staff during staff meetings. They had also introduced an observational framework to focus on the experience of people with PMLD living and staying at Linsell House, as a means of ensuring that their perspective was included in the further development of individual service delivery and improvements. The observational framework was also used in order to capture examples of good practices as well as areas for improvement. All observations were recorded and discussed at the weekly management meeting where an action plan was implemented and monitored. This demonstrated a drive to continuously improve the service provided.

In addition, during each visit by the peer advocates they produced a report of the interactions that they had observed and any areas for improvement they had identified. For example they had observed an incident in which a person's medicine had been dropped. They reported this in their feedback and the registered manager completed an investigation. This had resulted in the member of staff concerned being disciplined and provided with further training in medicines administration. The peer advocate reports gave the registered manager further insight into the service provided and enabled them to look for additional ways to improve the standard of care and support.

The staff team had introduced a system of 'champions' to support the implementation of best practice

within the home. These included an 'agency champion' who was responsible for supporting agency staff to follow the working practices introduced at the service and a 'CQC champion' who reviewed all CQC reports as they were published. They did this to identify any good working practices from other providers that could be introduced to further improve the service delivered to people. The service had introduced CQC logs that were used by staff to reflect on individual pieces of work and identify what went well or what required improvement.The format required staff to indicate which of the five key CQC areas had been evidenced. This further increased staff knowledge and helped to raise standards further.

The service had developed a quality assurance programme that was linked to the five key areas, safe, effective, caring, responsive and well-led. The registered manager and the unit managers also carried out a range of audits to enable them to identify any areas in which systems or processes could be improved. These had been planned and allocated on a monthly basis and included audits of agency staff profiles and induction, medicines stocks and records, environmental health and safety and support records. As a benchmark, managers reviewed the criteria against the traits identified in CQC's Providers Handbook, cross referencing across the five keys where appropriate. This approach celebrated what good was and flagged areas that required improvement. This continued the drive for improvement whilst acknowledging good practice. Where improvements had been identified action plans had been developed and monitored until the required actions had been completed. The service had developed a 'debriefing tool' that the managers used to reflect on lessons to be learnt. This was useful to improve practice and prevent further incidents as well as to identify trends.

As well as the informal chats at events that were used to gain feedback on improvements, people and their relatives were able to make suggestions for improvements they would like to see in a number of ways. These included completing the annual survey or in meetings with the registered manager or any of the unit managers. This enabled the registered manager to include their suggestions in the service development plan.

We saw that the last survey of relatives of people who used the service had been conducted in July 2015 and an action plan had been developed to address the areas in possible improvements had been identified. These had included improved communication with relatives and more information on the provider's complaints system. We saw that a system for supplying regular feedback to relatives who did not visit often had been implemented and copies of the provider's complaints policy had been sent to the relatives of everybody who used the service. This demonstrated that the registered manager listened to and acted on people's comments.

Staff told us that they had regular meetings at which they could discuss all aspects of the service and identify any improvements that they wished to see. The minutes of the last meeting held showed that topics discussed had included feedback from the 'CQC champion' on areas of good practice identified from the published reports, the work of the peer advocates and decoration of the home. The registered manager also told us that any lessons to be learnt from accidents, incidents observations or quality audits were shared at these meetings. This demonstrated that people were supported by staff that were committed to looking for continuous improvement to the services that they provided.

There was comprehensive documentation for every activity completed for and on behalf of people. We saw evidence logs that had been created to document every step taken when arranging a specific activity, such as a person taking part in a flying experience or going into hospital for a minor operation. These were stored securely within the units' offices along with people's care and support records.