Henshaws Society for Blind People

Henshaws Society for Blind People - 12 Robert Street

Inspection report

12 Robert Street
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Henshaws Society for Blind People - 12 Robert Street is registered to provide accommodation and personal care for five people who have a learning disability and an additional sensory impairment. The house is a large terraced property, providing accommodation over three floors. Each person has their own bedroom and they share communal areas and bathrooms. The ground floor has a kitchen, utility area, a dining room and a sitting room. Bedrooms and bathrooms are located on the first and second floors; there is also a staff office/sleep-in room on the first floor. There is on street parking at the front of the building and space for two cars on the premises. There is a small garden area to the rear. The house is located close to the centre of Harrogate, with easy access to all of the local facilities.

We undertook this short-notice inspection on the 18 March 2016. There were five people using the service at the time of the inspection. At the last inspection on 2 April 2014, the registered provider was compliant in the areas we assessed.

The service had a registered manager, although there was a process underway with the Care Quality Commission (CQC) to update this and register a new person as the manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they liked living at the service and felt safe.

We found people's health care needs were met. They had access to a range of community health care professionals when required. There had been one occasion when a person could have been supported to see their GP about a specific issue in a more timely way. This was mentioned to support staff and the deputy manager and an appointment was organised for them.

People received their medicines as prescribed. Medicines were obtained, stored, administered and recorded appropriately.

We found staff had received training in the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. Staff had a good understanding of the need to obtain consent from people prior to delivering care and support. They were aware of the need to make applications to the local authority when people who lacked capacity were deprived of their liberty. There were plans to discuss with the local authority as to whether one person met the criteria for DoLS. We have made a recommendation regarding the use of a code of practice when assessing criteria for DoLS.

We saw people had their needs assessed and were involved in planning their care and support. This enabled them to make decisions about how care should be delivered to them in ways that met their preferences and wishes, and what goals they wanted to achieve.

We saw people were encouraged to make their own decisions. We saw staff had developed good relationships with people who used the service and treated them with dignity and respect.

Staff encouraged people to maintain and develop their independence skills. Staff supported people to be involved in household tasks such as laundry and cleaning. People planned their own menus, shopped for their food supplies and prepared their own meals with support from staff. We saw there were plenty of fresh fruit, drinks and snacks available in between meals.

We saw people participated in a range of meaningful activities to promote their interests and hobbies. Staff supported people to access community facilities and to keep in touch with their friends and family.

We found there were sufficient staff on duty to support people's needs. Staff were recruited safely and all employment checks were in place prior to them starting work in the service.

Staff had received training in how to safeguard people from the risk of harm and abuse. They knew who to raise concerns with. Risk assessments were completed to help guide staff in how to minimise risks whilst ensuring people could make their own choices.

Staff had access to a range of training in order to meet people's needs. They also received support and appraisal in order for them to feel confident when supporting people. There was a system to identify when refresher training was required. The supervisions and appraisals were behind schedule for some people but management was aware of this and had plans in place to address this.

Equipment was maintained and the environment was safe, clean and tidy.

There was a quality monitoring system in place which included audits and questionnaires. This helped to identify shortfalls so action could be taken to address them. People told us they felt able to complain and staff had a policy and procedure to provide guidance when complaints or concerns were raised with them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff on duty to meet people's current health and social care needs. Staff were recruited safely.

People received their medicines as prescribed. The medicines were managed well and were obtained, stored and recorded appropriately.

There were policies and procedures in place to guide staff in safeguarding people from the risk of abuse and harm. Staff had completed safeguarding training and knew how to raise concerns.

The service was safe, clean and tidy. Staff observed for any repairs and these were actioned by the registered provider.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's health needs were met and they had access to a range of health care professionals when required. There had been an occasion when a change in one person's health needs had been recognised but staff had missed an opportunity to act on it in a timely way.

People were able to make choices about aspects of their lives and when they were assessed as lacking capacity for this, the registered provider acted within the principles of the Mental Capacity Act 2005. Recording the assessments of capacity and when decisions were made in people's best interest could be improved. Also the use of the Deprivation of Liberty Safeguards (DoLS) code of practice would help in making decisions about criteria for DoLS. We have made a recommendation about this.

Staff had access to training and support to help them feel confident when supporting people.

People shopped for their own food and prepared meals of their choice with support from staff. The staff tried to encourage

people to maintain a healthy diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

The staff approach when supporting people was observed as kind, patient and caring. Relationships had been developed between staff and the people who used the service.

People's privacy and dignity was respected and staff supported people to maintain their independence skills.

Confidentiality was maintained and personal records held securely.

Is the service responsive?

Good

The service was responsive.

People received care that was tailored to their specific needs. Assessments were completed and care plans were produced in a person-centred way which helped to guide staff in how to support people in the way they preferred.

There was a range of activities provided which helped people to have meaningful occupation and stimulation. People were supported to access facilities in the community.

There was a complaints procedure and people felt able to raise concerns in the belief they would be addressed. The complaints procedure was in alternative formats which made it more accessible for people.

Is the service well-led?

Good

The service was well-led.

There was a quality monitoring system in place which helped to identify areas of concern so issues could be addressed quickly.

The culture of the organisation was open which enabled people to speak out and raise concerns with the registered manager and senior managers.

Henshaws Society for Blind People - 12 Robert Street

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 registered 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 short notice inspection took place on 18 March 2016 and was carried out by one adult social care inspector. We provided 24 hours' notice because the people who used the service were often out and about in the community and we wanted to make sure there was someone available to assist with the inspection and to arrange time to speak to people.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service. We obtained information from the local authority contracts and commissioning team regarding their views of the service and checked to see if there were any outstanding safeguarding issues. There were no concerns from these agencies.

During the inspection we observed how staff interacted with people who used the service throughout the day. We spoke with four people who used the service, three of them in private. Following the inspection, we spoke with three relatives. We spoke with a support worker with additional responsibilities, two other support workers and a human resources officer. Following the inspection, we spoke with the deputy manager.

We looked at two care files which belonged to people who used the service. We also looked at other important documentation relating to them such as accidents and incidents and the medication

administration records (MARs) for the four people who received medicines. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf. We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We looked around the service to make sure it was clean and tidy.

Good

Is the service safe?

Our findings

People who used the service told us they liked living at 12 Robert Street and they felt safe there. They told us they helped to keep the service clean and tidy although they also said there was a cleaner employed two days a week. People told us staff were available to assist them when they required support. Comments included, "It's a very good service; yes, I do feel safe here. I'm really happy here", "I've been assessed as being able to manage home alone for an hour at a time which I like", "Yes it's ok, I like it here. The staff are all nice", "The staff are around to help us with living skills day" and "I have a drawer to lock my tablets in (the person self-medicated)."

The three relatives spoken with said, "The staff are very good with her. They are kind and helpful", "He has been there a lot of years and is as happy as Larry" and "We are very aware of [person's name] safety and have had no concerns currently with the present staff and procedures."

We found there were sufficient staff on duty. Staff supported people with their independent living skills on set days each week. This included planning menus, shopping for ingredients, preparing meals, cleaning their bedrooms, bathrooms and communal rooms, doing their laundry and attending any appointments. The staff on duty during the day fluctuated depending on people's support plans, their activities or access to community facilities that had been arranged. One support worker completed a sleep-in shift each night and there was a management on-call system for emergencies. There had been a restructure of the organisation last year and 12 Robert Street, and a nearby other location in the organisation, shared a staff team and registered manager. Staff said this had worked well. Recruitment was underway for additional staff which was at present covered by agency workers. The support workers told us they tried to ensure the same agency staff were used for consistency. This was confirmed by people who used the service.

We found staff were recruited safely and in line with the registered provider's policy and procedure. We saw staff recruitment documentation was held in their personnel files. Application forms were completed, selection made, interviews took place and then checks were carried out including disclosure and barring service (DBS) and obtaining references. DBS checks are used to help the registered provider ensure only suitable staff are employed to work in care settings. A human resources officer told us staff were not permitted to start work until full recruitment checks had been completed.

There was a policy and procedure to guide staff on how to safeguard people from the risk of harm and abuse. Staff completed safeguarding training and in discussions were familiar with the different types of abuse, the signs and symptoms which may alert them to concerns and how to refer an allegation to the appropriate agencies. Staff told us they tried to diffuse any arguments or difficulties which occurred between people who used the service before these escalated into safeguarding incidents. There had been two occasions when one person's anxieties had caused some upset between people who used the service and staff had intervened to address them. Although this was documented on incident forms, there was no analysis as to whether this reached the threshold of verbal abuse and no discussion with the local safeguarding team for advice. We mentioned this to the deputy manager and they told us they would assess any similar issues in future in order to notify the relevant agencies when required. We saw there was a

system in place to ensure people who used the service received the 'personal allowance' part of their employment support benefit; records showed us people received their benefits. These systems, and policies and procedures helped to keep people safe and to ensure their finances were not mismanaged.

Risk assessments were completed to guide staff on how to keep people safe and minimise the risks associated with specific activities of daily living. In one person's care file we saw these included areas such as health conditions, evacuation from the building, showering independently, self-medication and behaviours that could be challenging to the person and others. In another person's care file we saw the risk assessments had not been developed yet for behaviours which could affect other people. This was mentioned to the deputy manager to address.

We found people received their medicines as prescribed. Medicines were stored in a secure cabinet. When people went away on social leave, there was a system for checking medicines in and out of the service. We noted there was no thermometer to record the temperature of the room to ensure they remained stored in line with manufacturer's recommendations. This was mentioned to the support worker in charge of the service on the day of inspection and they told us this would be addressed. People had medication administration records (MARs) which highlighted when their medicines were received into the service and when they were administered to them. Staff noted when stock was carried forward from one MAR to the next months'. There was a small supply of homely remedies which had been approved by GPs such as paracetamol, simple linctus, indigestion tablets and senokot. We saw two people were able to self-medicate; there were systems in place to support them and oversee the process, and lockable facilities were available in which to store medicines in their bedrooms.

We found the environment was safe and there were systems in place for dealing with emergencies. There were first aid boxes, which were checked to make sure items used were replaced and each person who used the service had a personal emergency evacuation plan. Equipment used in the service was checked and maintained. All staff were responsible for highlighting any issues which needed repair or replacement so these could be logged with the registered provider and action taken. Staff completed a series of checks such as fire alarm tests, fire drills, the nurse call system, emergency lights and hot water outlets. We saw there were thermostatic valves on hot water outlets to ensure the water temperature could not scald people.

We saw communal areas were clean and tidy and people who used the service had no difficulty moving about the home and using the stairs. There were hand rails where required and nurse call bells strategically placed. There were soap and paper towels in communal bathrooms and toilets. Staff had access to personal, protective equipment such as gloves and hand sanitiser for use when required. There was an assessment for the risk of legionnaires and a contractor completed checks of the hot and cold water system.

Requires Improvement

Is the service effective?

Our findings

People told us they were able to see their GP and attend other appointments when required. They also told us they enjoyed their meals and were able to make choices about their lives. Comments included, "Staff support me to the doctors but I can make my own decisions", "Choices, yes I get up when I want and go to bed when I want; I go to bed when I'm tired", "I make my own decisions about finances and have my own card and PIN [bank card and number]", "I have full choices about shopping and cooking. I love it here and make choices myself", "We do what we want – it would be allowed if we wanted to stay up late. I can't think of anything we are not allowed to do" and "I choose what I want to do as part of my plan. I go out shopping on my own." One person who used the service told us it was very important they continued to have health screening as they had a relative who had died from cancer; they confirmed they attended for screening when contacted by their GPs surgery.

Relatives told us the regular staff team were skilled and knowledgeable about the people who used the service.

We found people had access to a range of community health care professionals such as GPs, dentists, chiropodists and opticians. Staff recorded when people had appointments with health care professionals and any advice or treatment prescribed. In discussions, staff were clear about when to contact health professionals for advice and guidance. However, we found there was a missed opportunity for staff to support one person to discuss increasing anxieties with their GP. We discussed this with the support worker in charge of the shift and they told us they would arrange an appointment quickly so the GP could review medicines and consider any need for additional treatment. Some people had received specialist or consultant support in the past but had been discharged as their treatment had stabilised their health conditions.

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. We saw assessments of capacity had taken place and four people had been assessed as having capacity to make their own day to day decisions. The MCA assessment for one person was still underway. We spoke with the deputy manager about this and they confirmed they were unsure if the person had a mental capacity assessment and best interest meeting to decide on their admission to the service. They said they would check this out with the commissioning authority. Staff were aware of the need for best interest meetings when major decisions were required and there was doubt about the person's capacity to understand the implications of the decision. We saw staff had discussed with one person's relative regarding the need to purchase an electric shaver from their monies, when their capacity to understand the need for the purchase was in doubt. However, this had not been completed and recorded in line with MCA best practice. This was mentioned to the deputy manager to address.

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). There were no people subject to DoLS in the service. We found there was one person who may meet the criteria for DoLS although this had not been discussed with the local authority responsible for supervising the process of assessment. We mentioned this to the deputy manager and they had been considering the criteria for the person and whether one to one support from staff affected this. They told us they will contact the local authority to discuss this.

We recommend the registered provider uses the MCA and DoLS code of practice to help determine whether any restrictions amount to a deprivation of liberty for the person.

We saw in staff team meeting minutes it was written that staff were to 'make sure' people participated in their living skills tasks before they participate in leisure or 'treat' activities. This implied choice could be restricted and we checked this out further with staff. In discussions with staff, they had an understanding of MCA and the need for people to consent to care provided. They spoke about 'encouraging' people to participate in living skills tasks rather than 'making sure' they completed them. Staff said, "It's very flexible, there is no way we would make a service user wait until after living skills are all done before treats – they could miss out", "All the service users have the capacity to make day to day decisions. If they don't want to get up that's ok; they can make their own choices", "People will tell us when they don't want to do something" and "There are day time plans for living skills and if they [people who used the service] wanted to change them, this would have to be planned in advance because of staffing levels and other people's living skills days. You can't make people do what they don't want to do."

We found people's nutritional needs were met. We saw some people had healthier diets than others but this was down to choice of the individual. People who used the service had their nutritional needs discussed during the admission process; this included their likes and dislikes, the type of cutlery they required and any assistance needed to cut food up and any swallowing difficulties. People planned their own menus in line with their individual likes, dislikes and preferences. We saw staff supported people with special diets such as vegetarian.

We saw staff had access to training to enable them to feel confident in their roles. Documentation indicated staff had completed training considered as essential by the registered provider. This included fire safety, moving loads safely, moving and handling people, food hygiene, health and safety, visual impairment awareness, medicines management, infection prevention and control, MCA/DoLS, first aid and safeguarding people from abuse. Staff had also completed autism awareness, specific legislation, equality and diversity, how to support people to be independent and how to diffuse difficult situations and manage behaviours which could be challenging. The training was a mixture of external facilitators, in-house training, practical sessions and watching DVDs with questionnaires. There was a system for identifying when training required updating. Staff told us they completed the right amount of training.

One member of staff told us they had had a recent supervision meeting, whilst in other cases this had been some time ago. We were also told that annual appraisals were behind schedule due to the restructuring last year. All staff confirmed they felt supported and could speak to the deputy manager and registered manager at any time and initiate a supervision meeting if required. We also saw staff had been given an appraisal self-assessment form to complete so these were being planned. However, we were unable to view supervision records as they were held securely and the registered manager was away from the service on annual leave and the deputy manager was on days off. Following the inspection, we spoke to the deputy manager about a system for the records being accessible during inspections. They told us supervision records were held electronically by the registered manager so copies of them could be sent to the human resources department to be held with staff's personnel file. They said this would solve the issue of accessibility of staff

supervision records. Comments from staff included, "I think I have had two supervisions since last October [2015]", "It [supervision meeting] was quite a while ago; I've not had any for 2015" and "I think my last one [supervision meeting] was about nine months ago."

We found there had been some adaptations to support the needs of people who used the service such as grab rails but people were independent and managed their environment well.

Good

Is the service caring?

Our findings

People spoken with were complimentary about the staff team. They said staff were caring and treated them in a kind way. Comments included, "The staff are really good. They help you to be as independent as much as possible", "I like going home to see my family but I love coming back; I have more of a life here and it's only five to ten minutes from town", "I'm really happy here", "I like the staff; they're good and don't shout" and "I think the staff are really great." One person told us they liked living at the service and the staff supported them, but they had been anxious lately and found it difficult to get on with everyone who used the service. Another person told us staff helped them to sort out differences which could occur when several people lived together in one house.

Relatives spoken with said, "They [the staff] are very good with them; they are kind and helpful and nothing is too much trouble. They do things [activities] with her and involve her in everything", "They [staff] keep in touch with us", "The staff are always friendly and helpful; both male and female staff cover their needs in respect of dignity" and "I can't find any little fault in the way they look after him."

We observed positive staff approaches and interactions with people who used the service. They provided explanations to people prior to tasks being carried out and ensured they had enough time to respond to questions asked of them. For example, we observed a member of staff speaking to a person as they were waiting for transport to be taken to the Arts and Craft Centre; they reminded them of their responsibilities to other people who used the service and discussed their excitement due to an activity they were taking part in that evening. This helped the person to remain calm.

We observed staff respected people's privacy by knocking on doors and waiting for them to answer before entering. Staff were also observed and overheard speaking to people in a kind way and patient way.

In discussions with staff, they were clear about how they would promote privacy and dignity and how they supported people to remain as independent as possible. Comments from staff included, "The service users are all independent with personal care tasks; we just need to supervise and prompt one person", "Their personal allowance is held in the office but they can take it out whenever they want; people have asked this as they feel it's safer but some people manage their own money", "People who can self-medicate are supported to do it" and "We support people with their independent living skills, shopping, cooking and cleaning. We're also helping with specific issues such as healthy eating and exercise."

People's care support plans showed they had been involved in developing them. Staff had supported people to complete a self-assessment of specific areas of need and discussed with them the goals they wished to achieve. Included in the care support plans were people's preferences, likes and dislikes. Some people had signed to confirm they were aware of the contents of the support plan and agreed to it. One person told us how they had developed their own file and colour-coded all their activities.

We found people who used the service were involved and consulted when new people were considering admission. Introductory visits were completed over a period of time so people could get to know one

another and establish friendships. The people who used the service had also been involved in an aspect of training delivered so they had an understanding of the potential resident's needs. We found staff supported people with their friendships and relationships with other people; these were respected by staff.

People were also involved in reviews of their care. One person told us they saw their social worker on an annual basis at their review and they were aware they could contact them at any time. They said they were able to express their views and were asked about their care at the service.

Documentation in care files indicated staff had recorded the birthdays of each person's family so they could be reminded and supported to send them cards if they choose.

Each person who used the service had their own bedroom; the bedroom and bathroom doors had locks for people to maintain their privacy. One person showed us their bedroom and described how they had chosen the colour of the paint for the walls. They said they were involved in making decisions about decoration.

We saw people were kept informed about issues within the service. There were notice boards with forthcoming events and people's weekly plans and menus. There was information on one of the notice boards about how to make a complaint. There was a pay phone in the dining area for people to use but some also had their own mobile phones and used these in the privacy on their own bedroom.

The staff were aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. People's care files and medication records were held securely and the care staff office was locked when not in use. Telephone calls to and from relatives or health and social care professionals could be taken in this office to ensure the conversations were not overheard. Staff supervision and appraisal records were held securely in the registered manager's office. This was located at another of the registered provider's services nearby. Staff personnel files and training records were held at the head office based at Henshaws College site. Computers were password protected and the registered provider had completed registration with the Information Commissioners Office (ICO) in line with requirements when maintaining computerised records.

Good

Is the service responsive?

Our findings

People we spoke with told us they could participate in activities when they chose to and also that they would feel comfortable raising concerns with staff. Comments included, "I like to listen to my books and watch tv; we have a Wii machine [electronic interactive game] downstairs", "I go shopping for clothes and food and go to Café Nero and the Arts and Craft Centre; you can chill out there and do jewellery, paperwork and multisensory", "We go out for meals together and go bowling", "I cooked my own tea with only minimal assistance. Sometimes I cook for [person's name] and sometimes he cooks for me", "I love going to the Arts and Craft Centre. I never get up and think, 'Oh God, I've got to go there again'; I love it", "I would go to [member of staff's name] if I had any complaints; he's my keyworker. They are all nice though" and "We have a complaints procedure. I've only had to follow it once ages ago; it was sorted out."

Relatives told us when there were any changes to the people who used the service, this caused some disruption. However, they were aware staff monitored this and helped any new person to settle in. A person who used the service confirmed this and said, "There have been some disagreements with people but they were sorted."

Relatives spoken with said, "I know she is always happy to go back so that says something; I think going to Henshaws was the best thing that ever happened to her", "Independence and choices are actively encouraged; she is happy with the home, and Arts and Crafts [Centre]", "I think he has a good quality of life there", "No, I don't have any complaints but I would raise them if I did", "Any issues are usually resolved when I visit or by email and telephone" and "One or two little things have been raised but they sort them out and do it so nicely; [member of staff's name] is particularly very good." Relatives confirmed reviews of their family member's support took place so care plans could be discussed and updated. One relative said, "We've been to every review each year and they are so good. They make sure he has a copy in enlarged writing so he can follow; they ask him for his comments."

We found people had assessments of their needs completed prior to admission to the service. We saw one person had supportive visits for several months before admission. These initially included afternoon visits and progressed to full days and sleepovers at the service. There was evidence relatives had contributed to the assessment process for one person by providing lots of information about their previous routines, preferences and likes and dislikes.

We found people were provided with care and support that was personalised to their needs. In each person's file, staff had spoken to people about their life history and completed a 'This is me' document with them. This included information about what was important to the person, what upset them and how staff could help them to relax, what their hobbies and interests were and how staff were support them. In one person's care file it was written they preferred a quiet work area in the kitchen. There was information about how independent each person was with activities of daily living and how much support they would need. We saw information was collated into a short profile which covered issues such as mobility, personal care, behaviours that could be challenging, communication, eating and drinking. There was a separate food and nutrition form which highlighted any allergies the person had, any special diets, likes and dislikes, and how

the person was able to prepare meals. One person had a specific plan to manage their epilepsy with guidance for staff on the use of rescue medicines.

Part of the assessment process involved the person working with staff in identifying and scoring their needs on an 'outcome star' chart. This covered areas such as managing vision, health and wellbeing, where they live, looking after themselves, safety, work, activities, keeping in touch with family and friends, money and self-esteem. The information in assessments was used to produce plans of care for people. For example, these included daily routines, goal setting and guidance for staff on how to support people in the ways they preferred. We saw one person's goals were to increase the variety of meals they ate and to exhibit their art work.

We saw people were supported to access local facilities such as shops and cafes. In this way people were encouraged to be part of their local community. The staff confirmed the food and other shopping budget for the service were distributed evenly between the five people who used the service. This enabled them to shop individually for food and other household items. The staff said that if any monies accumulated from this system, a meal out would be arranged for everyone to participate in if they choose.

We found people were involved in planning care and in making decisions about what they wanted to do and how to spend their days. All five people attended the Arts and Craft Centre on various days which was provided by the registered provider. People told us there was a range of workshop sessions they could participate in such as jewellery making, artwork, crafts, beauty and wellbeing, paper work, woodwork, pottery, textiles, cookery and horticulture. There were discos held there on Thursday nights and public events such as 'Friday Night Mixers'. Two people attended a college for an IT course and other people accessed a local gym for swimming sessions. People were encouraged and supported to continue with their hobbies and interests such as visiting London to see shows and participating in tandem rides.

Staff told us people were involved in planning days out in the summer. Last year these included a walk around Swinsty Reservoir, a visit to James Herriot Museum in Thirsk and Yorkshire Wildlife Park in Doncaster, a day trip to Scarborough and bowling and a meal out in York. One person also had an overnight stay at Lake Windermere during Christmas festivities.

People's bedrooms and communal rooms in the service were homely and personalised with photographs and items important to them. There was a television and DVD in the sitting room and music equipment and a computer in the dining room for communal use. There were lots of art work on the walls and also small items of furniture such as tables with mosaic tops that people had completed.

There was a complaints procedure which was displayed in the service; we saw this was in braille format which made it more accessible for some people. This described how people could make a complaint and how to escalate it if required. The staff had access to a complaints policy and procedure to guide them in how to manage complaints.

Good

Is the service well-led?

Our findings

There had been a restructuring of the organisation last year and the registered manager of another Henshaws service close by was underway with an application to add 12 Robert Street to their registration. People who used the service and their relatives knew the registered manager's name and how to raise any issues or concerns with them. People who used the service also said they had completed questionnaires about what they thought of 12 Robert Street. Comments included, "The managers are really good [names of the registered manager and deputy manager were mentioned]; if there is a problem you can talk to them" and "I've completed a 'what do you think' questionnaire; one of the managers comes monthly to visit and speak to us and staff." A relative said, "[Registered manager's name] is very organised and has good staff under her."

The organisation had a statement of purpose and service user guide which identified its aims and values. These included being open, honest and transparent with people, consulting with and involving them decisions, treating people as individuals, providing them with the opportunity to make their own choices and meet their own goals, and maximising their ability and independence. It also spoke about valuing staff. We found these aims and values worked in practice within the service.

Staff told us they felt able to raise any issues with the registered manager and senior managers. They confirmed there was good communication within the service and they had team meetings at which to express their views. Comments included, "The culture is transparent here and there is a support network. Service users can raise concerns and so can staff", "I feel supported and my responsibilities are clearer", "We have team meetings and share information", "We get information in emails and memos" and "We have a good staff team." We saw there were managers meetings and some senior support staff were able to attend these; information from the managers meetings was cascaded to staff.

We saw there was a quality monitoring system in place which consisted of audits and questionnaires for people to complete. The questionnaires were completed every six months and we saw the ones for December 2015 and June 2015. These asked people their views on areas such as the home environment, meetings, health needs, meal choices, key workers and other staff, activities and occupations, involvement, privacy and whether their friends or relatives were welcomed. They also asked people if they knew how to make a complaint, whether they took part in fire drills, whether they had been involved in staff interviews and if their care had been reviewed. We saw any issues were addressed by staff and suggestions were acted on.

The service had compliance audits completed by other managers. We saw the audit for December 2015. This covered areas such as health and safety, the exterior of the building, security, housekeeping and log books such as fire safety, water temperature checks and complaints. The auditor also checked two people's care plans, whether meetings had taken place, medicines management and accidents. There were also discussions recorded with staff and people who used the service, although it was not recorded which people who used the service and which staff had been spoken with. An action plan was developed from the findings and followed up to check on progress.

Staff told us there was a system of recording accidents and incidents so that learning could take place. They said management viewed any completed reports and the Community Housing Support Manager had oversight of them.

There were meetings for people who used the service and staff to express their views. These were recorded and minutes were on display. The staff team meetings covered areas such as key worker roles, repairs that were required, training and the needs of people who used the service. The meetings for people who used the service focussed on what activities they wished to participate in, planned outings and parties.

Links had been made with the community such as colleges, gyms, museums, shops and theatres. People who used the service told us they accessed these local community facilities supported by staff and minutes of meetings reflected these visits and activities.

We spoke with the deputy manager about the information they received, about staff and their skills, from the agency that provided staff when required. The deputy manager told us they had a contract with the agency to provide one to one support for a person. The staff had to have experience and training at a specific level to complete the one to one support. They also stated the agency made information packs available regarding the staff's skills for them to check out.

We saw the registered provider and registered manager were aware of their responsibilities in notifying the Care Quality Commission and other agencies when incidents occurred that affected the safety and wellbeing of people who used the service.