Milewood Healthcare Ltd

Hudson Street

Inspection report

24-25 Hudson Street
Whitby
North Yorkshire
YO21 3EP

Tel: 01947603367
Website: www.milewood.co.uk

Date of inspection visit:
25 October 2016

Date of publication:
06 December 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

Hudson Street is one of 14 services owned by Milewood Healthcare Limited. The service provides accommodation and personal care for up to 12 people with learning disabilities or autistic spectrum disorder. Accommodation is provided in two adjacent terraced houses in the seaside town of Whitby on the North Yorkshire coast. On the day of inspection, there were 12 people living at Hudson Street.

The service had 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.

This inspection took place on 25 October 2016. At our previous inspection on 11 June 2015, we saw that people were not safe because there was inadequate maintenance and a lack of cleanliness. In addition, audits carried out had not identified these as areas for improvement.

At this inspection, improvements had been made and the service was safely maintained and clean. Audits had improved and the registered manager had drawn up action plans arising from the results of these.

Medicines were safely handled to protect people. The registered manager assessed risks in consultation with people and plans were put in place to minimise these. Risk plans were subject to regular review with people involved.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the service. The service had sufficient suitable staff to care for people and staff were safely recruited.

The environment was safe for people, though their individual rooms were at times disorganised and cluttered which could lead to risks around fire safety and trip hazards. However, staff explained they worked alongside people to support them to maintain their environment safely and we saw that they intervened when necessary to protect people.

People were protected by the infection control procedures in the service.

Staff supported people appropriately when they had behaviour which may challenge others and they consulted with people about their risk plans.

Staff had received suitable training to ensure that people received care appropriate for their needs.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLS. People were protected around their mental capacity.

People's preferences around food and drink were recorded. People were supported to eat healthy meals and they told us they enjoyed the food. Specialist advice around people's nutrition, medical care and mental health needs was sought and advice was followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which supported them towards independence. Daily activities were in line with people's preferences and interests. Staff were responsive to people's wishes and understood their personal histories and social networks so they could support them in the way they preferred. Care plans were kept up to date and reviewed each month. People were given opportunities to take part in drawing up their care plans, their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were recorded. Everyone we spoke with told us that if they had concerns, they were addressed by the registered manager who responded quickly.

The service had an effective quality assurance system in place. Hudson Street was well managed and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who were important to them, staff and health care professionals, in order to identify required improvements and put these in place. Records around good governance were clear and accurate and led to planned improvements.

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.

Risks to people's safety were assessed and plans were in place to protect people from the risk of harm.

People were protected from the risks of acquiring infection because the service had good infection control policies and procedures and staff acted on these.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us they were well cared for and staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide appropriate care.

The service met people's health care needs, including their needs in relation to food and drink.

The registered manager had made provision for decisions to be made in peoples best interests in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people.

Staff involved people in all decisions.

Staff had respect for people's privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests, which supported staff to offer person-centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well- led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Hudson 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 inspection took place on 25 October 2016 and was unannounced. An adult social care inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed all the information we held about the service such as statutory notifications. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We had asked the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This helped us with our planning.

During the inspection, we spoke with six people who used the service, a visitor, three care workers, the deputy manager and the registered manager. We looked at care and support plans in detail for four people and checked three care worker employment records. We examined the training records and other documents relating to the running of this service such as audits and meeting minutes. We observed a meal time at the service and checked to see whether medicines were managed safely.

Following the inspection, we spoke with a health care professional who was a registered learning disability nurse. We also contacted local authority commissioners. We received written feedback from three further professionals; a clinical case manager and two health and social care professionals.

Good

Is the service safe?

Our findings

At our previous inspection on 11 June 2015, we judged that people were not safe because there was inadequate maintenance and a lack of cleanliness. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. In addition, audits carried out had not identified these as areas for improvement and we had made a recommendation about quality assurance. The registered manager sent us an action plan on 10 September 2015 outlining their plans for improvement.

At this inspection we found that the registered manager had carried out improvements to the cleanliness of the service. Toilets in people's rooms were clean, carpets had been replaced either with new carpets or, where appropriate, impervious laminate flooring. The service had infection control procedures in place and staff told us they followed these. Staff told us they kept dirty and clean laundry separate to minimise the risk of cross infection. The communal areas had been redecorated and were fresh and pleasant. People who lived at the service showed us the communal areas with pride and told us they enjoyed living in a brighter environment.

Staff explained that they worked alongside people to develop their independence and maintain a safe environment. They told us they intervened when people's care needs meant their rooms were no longer meeting their needs with regard to cleanliness, fire or trip hazards. We saw that efforts had been made to work with people along these lines in daily notes and in care plans. The living environment was improved following the last inspection and the service was no longer in breach of this regulation.

People told us that they felt safe at Hudson Street. One person told us they wanted to go out unaccompanied but staff had explained this was not safe because of their health needs. The person understood this, and told us they were supported to go out with staff. Another person said, "Mam says I'm a lot safer here." They agreed they were safer than where they had previously lived. Another person described the risk assessments and protocols which had been formulated with staff to safeguard them. They said, "I don't carry much money with me because that means other people might take it off me." They understood the measures put in place to keep them safe and agreed with them. They told us this helped them feel more in control of their life. One person told us staff had taught them where the safe places were in the town if they needed to use them when they were out unsupported. A visitor said they trusted staff who were "spot on" in informing them of any incidents as soon as they happened.

Care plans identified a person's level of risk and records showed these were regularly updated to reflect people's changing needs. People's records confirmed they had been involved in their risk management plans. Mental health professionals told us the registered manager and staff managed risk appropriately. For example, one professional had written that the staff supported service users to be, "socially inclusive and as independent as they can be without restricting their liberties." People had been referred to the NHS learning disability service for further assessment, where necessary, for positive behavioural support. There were clear risk management plans in place where they were needed. For instance, if people displayed behaviours that challenged others, their plan identified any triggers for the behaviour, preventative measures staff could take, told staff how to react and highlighted any safety measures they could take. Staff told us their

approach to risk was responsive to people's changing needs and mental capacity. They told us the home had an open and positive approach towards managing risk. This meant people received support to match their specific needs, making sure they experienced positive outcomes.

We saw there were safeguarding policies and procedures in place. In the Provider Information Return (PIR) the registered manager had told us:

"Any issues that do arise within the home or with the staff and people who we support are reported promptly to line management and any appropriate external bodies, such as the safeguarding authority, the individual's own care teams, and the Care Quality Commission (CQC)."

Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle-blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us they calculated this using the numbers and dependency levels of the people living at the service at any time. They told us the service operated as two separate units, though they were under one registration. This meant there was a senior care worker on duty in both numbers 24 and 25 Hudson Street with care staff to support them. They said that sometimes it was difficult to cover shifts without asking existing staff to work extra hours or using agency staff. This was due to staff turnover and difficulty in recruiting. Staff told us they were managing to cover shifts and they never had unsafe staffing levels. The registered manager told us they were in the process of recruiting and when we looked at the rotas, sufficient staff had been deployed to ensure people's needs were met. We were satisfied the provider had done all they could to minimise any risk to people who used the service and people told us they still went out and followed their preferred routines.

We looked at the recruitment records for three care staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff and two references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. In the PIR, the registered manager told us that the people who lived at the service were involved in the recruitment process and one person told us about how they were involved in interviewing prospective new staff. They said this was, "to make sure that I like them and they are good people." This meant the registered manager had taken steps to reduce the risk of employing unsuitable staff.

People's medication was managed safely. It was stored in a locked cupboard in an identified room in number 24 Hudson Street and in individual medicines cabinets in number 25 Hudson Street. The registered manager operated a Monitored Dosage System (MDS) which is a medication storage device designed to simplify the administration of solid oral dose medication. There was a care plan for each person relating to their medicines and there were risk assessments where appropriate. Staff completed medicine administration records correctly. There was a medicines policy and procedure for staff to follow and staff had been trained to administer medication safely. Protocols were in place for each individual who may need

'when required' (PRN) medicines. One person who lived at the service told us they were aware of the medication they were prescribed and why they were taking it. They told us staff had discussed their medicines with him. They said they received their medication on time, "dead on the dot". Monthly medicine audits were completed to check on stocks and make sure recording was accurate and safely completed.

We saw there was a fire risk assessment in place and checks had been carried out to ensure the system worked properly. There was a record of fire safety checks which we saw took place in line with the requirements of fire safety legislation. Window restrictors were in place for people' safety. Each person who lived at the service had a personal emergency evacuation plan in place (PEEP), to ensure they could be supported safely in case of fire. Accidents and incidents were documented and actions determined. These were reviewed when monthly audits were completed.

Good

Is the service effective?

Our findings

People told us they received support to access health care such as GPs, nurses and mental health professionals. One person described that they had become unwell a few weeks before and staff had supported them to attend hospital for a medical assessment. Another person told us they enjoyed the food at the service and they enjoyed 'take away' nights, and going out for meals in cafes and restaurants. People agreed that staff respected their choices and supported them to make decisions. One person said, "I painted my bathroom the colour I wanted." Another person said, "I can decide who I see and who I don't see." A visitor commented that their relative's health condition was now better managed than it was where they lived before which had led to a better quality of life for them.

Each member of staff had an induction to the service. Staff confirmed they had received induction before they began their comprehensive training. During this time, they developed a good understanding of each individual person's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how their needs should be met. For example, one member of staff accurately told us about the care a person required, including how they should be supported with their mental health and their health action plan to ensure they had a good quality of life.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they were confident. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the home. The registered manager told us about the training they considered mandatory in the Provider Information Return (PIR) and that 29 staff had achieved a national vocational qualification (NVQ) at a minimum of level two with other staff having this qualification at level three or above. They wrote, "Staff members are provided with training on all diagnoses of individuals who live at the home." Training included specific areas relevant to the needs of those being cared for at the service, for example, buccal midazolam training, bipolar disorder, autism and schizophrenia. We checked training records and found that although most training was up to date, some training for some staff was past the date when it should be renewed. However, there was a plan in place to rectify this.

Staff told us they received regular supervision and appraisal. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

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 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing their ability to make decisions. People's need for advocacy involvement was assessed and recorded. The service had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions.

Seven people at the service had a DoLS authorised by the local authority, however, the service had not notified CQC other than in the PIR. These DoLS had originally been put in place before the time CQC began to ask services for this information. However the registered manager was not aware that when renewed DoLS applications were authorised, CQC required a notification from the service by law. Once the registered manager was aware of this they assured us they would notify us without delay.

People told us they were regularly asked for their consent to care and they were supported to make choices. We observed staff routinely asked for people's consent before giving assistance and supported people to make choices. For example, staff explained options and reminded people about what they had enjoyed in the past. Care records showed people's consent to care and treatment was sought and that they were supported in making choices and decisions.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advise. An example of this was a decision about a person remaining at the service.

The home had links with specialists, for example the learning disability nurse, social care professionals and mental health professionals. In the PIR, the registered manager told us the staff reviewed and documented all health care visits and records confirmed this. Advice from specialists was written into care plans and daily notes confirmed the advice was being followed. This advice helped staff to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person or someone they wished to be involved.

Professionals told us staff consulted with them promptly and followed their advice. For example, one professional we contacted by e-mail wrote, "I have no concerns. Always found them forward thinking, good communication and observed positive relationships with (the person)." Another professional we telephoned told us, "They are good at picking the phone up to discuss how the plans are working. The manager and staff are committed to working with people in a really positive way."

Each person had a health action plan and a hospital passport which gave health professionals important information about each individual should they need to visit the hospital. This was arranged in a traffic light order of priority which was easy and clear for hospital staff to understand. Where necessary, people had pictorial plans which supported them to understand their health care.

People's need in relation to food and drink were recorded in their plans of care. Likes, dislikes and allergies were recorded and the choices people had made for each meal. We observed a lunch time meal where people were being supported in a friendly and enabling manner. The staff took the lead in cooking for the people who were having lunch and we noted this was in line with their care plans. People took part in

clearing away and washing up. The atmosphere was relaxed with conversation and laughter between staff and people who lived at the service. Lunch time was flexible with people having a choice of meals. Staff discussed with people what they wanted for their evening meal. People told us they went out food shopping with staff and were involved in planning their meals. Those people who were following specialist diets were supported with this. Staff told us they worked with people in line with their mental capacity around food choices. Some people made a decision not to follow dietary advice at times and staff respected this. Staff also told us they discussed the consequences of certain food choices with people and what the effect may be on their health. Staff gave people positive encouragement when they did eat in a way which promoted their health.

Good

Is the service caring?

Our findings

People told us staff were kind and helpful. One person said, "They are good really, I trust them all." We spoke with a visitor who said, "(The person) loves everyone here." We asked the visitor if the staff were caring and kept in touch with them. They agreed and replied they enjoyed chatting with staff and said, "They're all nice."

In the Provider Information Return (PIR), the registered manager told us, "Staff show empathy and understanding for the needs of the people who we care for." We spent time with people in the communal areas and observed that this was the case. There was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw staff encouraged people to express their views and listened to their responses. Staff reassured people where this was appropriate and showed they were aware of people's likes and dislikes, those people who were important to them and details of their personal history. For example, one member of staff told us about a person's interests around sport and recreation and were able to tell us what they had achieved and some of the goals they had decided on. Staff gave the impression they had plenty of time to spend with people and they were interested in what they had to say.

We observed staff approached people with respect and concern for their dignity. Staff told us they respected people and spoke about using a kind tone of voice, listening to them and being sure to support people in a way which made them feel comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support. For example, one plan contained information for staff about how to support a person when they became distressed around a specific circumstance. The directions for staff were clear and detailed so they had the information they needed to support the person in a consistent and positive way.

People were assessed around their need for advocates or Independent Mental Capacity Advocates (IMCAs) so their voices and wishes could be heard and acted on. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

Care plans contained details of people's preferences, needs, hopes and goals. The staff made people feel they mattered by consulting with them regularly in both formal and informal ways; for example through monthly service users meetings, one to one time and group discussion. People were empowered and had a direct influence over their care through involvement in their reviews where they discussed their care plans, days out or holidays. People were also consulted about decisions within the home such as how it was to be decorated. Meeting minutes confirmed this. People who lived at the service were involved in recruitment and told us they looked for staff who were kind and "good people".

Staff showed they understood people's priorities and values, using the information recorded in care plans to support people to develop independence. For example, one person told us about how in the past they had felt the need to leave the service without telling staff, but that now they always told staff when they were going out because they understood why it was important for their safety. Staff told us they had worked with the person to understand their reasons for acting as they had and to work with them based on building trust

and a sense of personal responsibility.

Another person told us about voluntary work they had been involved in which they had attended with a member of staff to support them. Having a member of staff with them allowed the person to feel sufficiently confident to take a step into the workplace. Staff told us about how important it was to another person that they keep in touch with family and friends and how they supported this to happen whilst keeping the person safe.

Each person had a key to their room and people told us their privacy was respected unless there was an emergency which meant staff had to gain access for a person's safety.

Visitors told us they were made welcome. They told us they agreed their visit in advance with the person and staff so that people could plan their days which meant people knew when visitors were coming. Sometimes it was necessary to manage visits, for example, when having a visitor may have an adverse effect on a person's mental health. Staff told us they respected when people did not wish to see visitors and they understood there were times when people may wish to spend time alone.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person said, "I like it here because we do all sorts of things." Another person said, "I like gardening and I look after the front garden." A visitor told us their relative went out regularly to local shops, cinema, cafes, college and the gym. They told us they had been pleased when local shopkeepers knew their relative and chatted with them, knowing their name and their hobbies. They said this showed the person regularly went out into the local community and had a good relationship with people they saw outside of the home.

Staff and the people who lived at the service gave us examples of how they worked together to celebrate people's individual personalities and support their needs. Staff explained that by knowing people's life histories and preferred ways of communicating, they were able to support people to plan their care. One person told us that staff supported them to follow an interest in the local history of the area and around the fictional character Count Dracula and the 'Goths' who regularly visited the town of Whitby. Another person told us they often visited the local paper shop and went out food shopping with a member of staff, which was time they appreciated. One person described how they attended a local fitness class with a member of staff, that they played football regularly and were planning a dog walking job. People spoke with enthusiasm about attending a Halloween disco planned that night and were preparing their costumes. Staff told us about how they supported a person to maintain their relationship with their girlfriend and promoted their contact with friends and wider networks of support.

Staff told us people regularly visited cafes, clubs and social events such as discos and other events according to their preference. A social care professional wrote, "Staff escort service users in the local community. They also support them to be socially inclusive and as independent as they can be without restricting their liberties."

This demonstrated the service had good links with the facilities available in the local community and supported people to use them in a way which was meaningful to them.

Staff told us about the values and approaches they used to help people achieve their full potential. This involved trying different ways to support people and help them achieve their goals. For example, this may mean working with an individual gradually over a period of time to build confidence or it may mean providing a person with information such as bus timetables, or holiday brochures to support them to explore leisure options. A health care professional wrote to us and said, "I have observed staff thinking out of the box for solving issues and providing support with finances, employment, voluntary work, regular holidays and activities. There is a person-centred approach from management and the staff." We found people were confident about expressing their achievements and staff supported them to tell us about them.

Staff supported people to make key decisions about important areas of their care such as where they would live, who they would see and where they would go. This included decisions about their health and the members of staff to support them with their personal care. People had also made decisions about which staff would support them to do interesting things.

People had contributed to their care plans and risk assessments and were regularly involved in reviews so they continued to receive the individual care and support they needed. We saw people's health action plans showed the views of relatives and professionals had been taken into account when this was appropriate. The health action plans had been regularly updated so they reflected people's current needs. People told us they were able to change the way their care was planned at their regular care reviews. A clinical case manager we contacted told us, "(The person) was very happy with the placement and was fully involved in their own care planning." Another health care professional wrote to us, "(The person) has always been present at reviews and had been given opportunities to express wants and wishes."

People were formally consulted for their view in monthly house meetings, where people had the opportunity to express their views and to make suggestions which staff told us they put in place whenever possible. People told us that menu changes, outings and concerns about the actions of others who lived at the service were all discussed at these meetings.

The registered manager told us in the Provider Information Return (PIR) that the service had a complaints policy and procedure. They told us they did not often receive complaints. They did describe one complaint however, which had been recorded and they had investigated this according to policy. People we spoke with said they had not needed to make any complaints about the care received because staff took action to investigate and resolve any concerns they had. One person we spoke with told us if they had any concerns they were able to talk to staff to resolve them quickly. The person was confident if they ever wanted to make a complaint staff would listen to them and take action to resolve their complaint. One person said, "They are alright here. They will listen and do something to help." A relative we spoke with told us, "I have no complaints at all." Staff we spoke with knew how to support people if they wanted to make a complaint about the care they received.

Good

Is the service well-led?

Our findings

People told us the service was well-led. One person said the registered manager was 'brilliant'. A visitor told us the registered manager was approachable. One person told us, "They all know what they are doing. They do what they should do." Another person said staff listened to the registered manager. One person told us, "They ask us what we think of things and we get to change things if they aren't right."

The service had a registered manager in place. In the Provider Information Return (PIR) the registered manager told us there was a clearly defined line management structure which ranged from support workers, seniors care workers, deputy managers, registered manager, operations manager and the board of directors. They received support from the operations manager who completed a monthly visit and also visited informally at other times during the month. On the day of inspection, an operations manager changed their plans in order to support the registered manager during the inspection. This meant the registered manager was better able to spend time with the inspection team to facilitate this process.

Staff told us the registered manager was often available for a chat and to find out how people were. We saw that people knew the registered manager well and they in turn knew individuals and talked with them about their lives and what they were doing with their day. All the people we spoke with told us they thought the service was managed well and the registered manager was approachable. We observed the registered manager spent time with people in the houses and people were relaxed with them.

The registered manager spoke clearly about the vision and values of the service and understood their role was to lead by example and to provide a service which supported people to develop and gain a sense of well- being.

Every member of staff we spoke with told us they thought the service was well-managed and they enjoyed working at Hudson Street. Staff said they were comfortable to raise any suggestions about how the service was run and the care people received. They said they were able to obtain advice and support from the registered manager and senior staff when they needed to. This included on call support at any time of the day or night. Staff gave us examples of how they had been able to gain advice quickly when people were anxious or ill so people received the care they needed.

All the staff we spoke with said they were supported in ways which made them feel valued by the registered manager. One member of staff said, "They never mind if you go to ask for advice. They take time to talk things through with you." Staff meetings took place each month, where staff were encouraged to voice their views and have a say. Meetings covered care topics and practical working arrangements.

People were encouraged and supported to give feedback and make suggestions about their care. They had opportunities to contribute to staff recruitment and selection and their views were sought in regular service user meetings in each house. People agreed the service user meetings gave them the opportunity to air their views and to make suggestions to improve the service. One person we spoke with said people and staff discussed any suggestions together. The person told us how some suggestions they had made about

decorating the lounge and dining room had been made in these meetings. Another person told us, "Staff ask us what we want to see happen." We observed one person asking about building work that had been carried out to the roof area and staff explaining to them what had been done and that the damaged area to the plasterwork in their room could soon be repaired. Staff told us people, relatives and staff always knew about plans for the service and what interesting things were planned, as the details were recorded in meeting minutes and shared with people who visited the service.

The registered manager had developed effective working relationships with external organisations, such as day placements and clubs. Staff who supported people at these external organisations were informed about their care plans so they would benefit from a consistent approach to care.

The registered manager said they felt supported by the registered provider who made sure resources were in place to support the development of the care people received. They explained in the PIR that they had developed an annual quality assurance system which was based on Milewood Healthcare Limited principles. This quality assurance system included regular monitoring of such areas as care planning, health and safety, infection control and medicine handling. We saw this was in place and action plans were agreed with the people and the registered provider. People who lived at the service, health care professionals involved in people's care and visitors were surveyed for their views, though the registered manager agreed that they had not been as proactive as they could have been in distributing surveys and encouraging them to be completed. However, some had been returned and the registered manager had acted on people's comments.

The service had an up to date service user guide and statement of purpose which gave useful information to people who were planning a move into care. Policies and procedures were regularly updated to reflect any changes in legislation and the care given.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the service to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the service, which placed the people at the heart of care.

Notifications had been sent to the Care Quality Commission by the service as required and they also sent notifications to other bodies such as the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous occurrences Regulations (2013) (RIDDOR). This meant that the service provided for external scrutiny of incidents and accidents so that people's wellbeing was protected.