United Response

The Hollies

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 23 November 2017 and was unannounced.

The Hollies is registered to provide care and support for up to 14 people living with a learning disability and/or autism, within the 40s to 60s age range. The service comprises two distinct areas with separate entrances known as 'The Hollies' and 'Number 84'. At the time of our inspection, eight people were living at the service, three people at The Hollies and five people at Number 84. Communal areas include a living room, dining room and kitchen in each part of the home. Number 84 has accommodation over two floors and The Hollies is all on ground floor level.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in post. 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.

At the last inspection, we found areas for improvement in relation to the guidance for 'as required' medicines, the drawing up of capacity assessments and staff understanding in relation to mental capacity legislation and that people and/or their relatives were not involved in reviewing their care. At this inspection we found that improvements had been made and the rating in each domain has improved from 'Requires Improvement' to 'Good'.

Staff had completed training in the administration of medicines. Medicines that were administered on an 'as required' basis were done so safely. People understood what their medicines were for and why they had been prescribed. Medicines were managed safely. People were protected from potential abuse and neglect and staff had completed training in safeguarding adults at risk. People felt safe living at the home. People's risks were identified, assessed and managed safely and risk assessments provided detailed information about people and how staff should support them to mitigate risks. Accidents and incidents were logged and when things went wrong, lessons were learned. Duty of Candour was applied and the provider ensured that staff were open and honest in their communication with people and their relatives. Staffing levels were sufficient to meet people's needs. Safe recruitment practices were followed. People were protected from the risk of infection and the home was clean and odour free.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff had a good understanding of the Mental Capacity Act 2005 and associated legislation. People were only deprived

of their liberty where they were deemed to lack capacity in relation to specific decisions. People's needs and choices were assessed so their care and treatment was delivered effectively. People were encouraged to be as independent as possible. Areas of good practice were shared between the provider and registered manager and cascaded to staff. Staff had the skills, knowledge and experience they needed to look after people effectively and had completed a range of training. Staff had regular supervisions. People were supported to have sufficient to eat and drink and were encouraged in a healthy diet. The service worked with a variety of organisations to deliver people's care and support. People had access to a range of healthcare professionals and services. People's rooms were personalised and decorated in line with their preferences.

People were looked after by kind, caring and friendly staff and positive relationships had been developed. People felt relaxed and at ease with staff who knew them well. Relatives spoke positively about the care staff. People's communication needs were taken account of so that they were enabled to make decisions relating to their care. People were treated with dignity and respect and their independence was promoted.

People and their relatives were involved in reviewing the care and support provided and review meetings took place. Care was person-centred and responsive to people's needs. Care plans were provided in an accessible format and people, where possible, had signed their care plans to show their agreement with them. Care plans included people's personal histories, care and support needs and were detailed in providing guidance for staff, for example, in relation to providing support to people perceived as having challenging behaviour. People pursued activities of their choosing and that were of interest to them. Some people went out independently and could use public transport. Complaints were listened to and acted upon and the provider's complaints policy was accessible and in an 'easy read' format. When people reached the end of their lives, people left behind at the home were supported by staff through the grieving process. People's end of life wishes were recorded within their care plans when they felt able to discuss these with staff.

People's rights to a meaningful life were promoted and the registered manager was passionate about this. She supported people and valued staff to do their best. The culture of the home was person-centred, open and inclusive. Staff were positive about working at the home and felt the registered manager was supportive. Staff were asked for their feedback about their employment through annual surveys sent out by the provider. Staff attended staff meetings and were encouraged to make suggestions. People were involved in developing the service and weekly house meetings were held. Relatives were happy with communication at the home from the registered manager and staff. Auditing systems were effective in measuring and monitoring the quality of care and the service overall. Notifications that the provider was required to send to the Commission by law had been sent and the rating awarded at the last inspection was on display. The service worked in partnership with other agencies to provide holistic care.

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.

Medicines were managed safely.

Systems were established to protect people from potential abuse and neglect and all staff had completed safeguarding training.

People indicated they felt safe and their risks were identified, assessed and managed appropriately by staff. Accidents and incidents were logged as needed and lessons learned when things went wrong.

Staffing levels were sufficient to meet people's needs. Recruitment processes were effective when new staff commenced employment.

People were protected from the risk of infection. The home had recently been updated and refurbished and was clean.

Is the service effective?

Good

The service was effective.

Staff worked within the principles of the Mental Capacity Act 2005 and understood the relevance of this and associated legislation.

People's needs and choices were assessed so they received holistic care. Staff were matched with people.

The registered manager kept up to date with good practice and shared this with staff. Staff had the skills, knowledge and experience they needed to look after people effectively. Staff completed a range of training, including vocational qualifications and had regular supervisions.

People had sufficient to eat and drink and were encouraged to maintain a balanced diet. People helped with the preparation of food.

The provider worked with a variety of organisations to deliver effective care and people had access to a range of healthcare professionals and services.

People's rooms were personalised and decorated in line with their preferences.

Is the service caring?

Good

The service was caring.

People and staff had developed kind, caring relationships. People received the support they needed and their communication needs were met in an accessible way.

People were involved in decisions relating to their care and they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed with them and their relatives. People received personalised care that was responsive to their needs. Information was presented in an accessible way so people could understand what had been written about them.

Care plans were detailed and provided guidance for staff on people's care and support needs.

People chose what they would like to do each day and activities were planned in line with their preferences. People's cultural and spiritual needs were met.

Complaints were listened to and acted upon. The complaints policy was written in an accessible way.

Two people had passed away recently and staff were sensitive to people's needs and emotions. Support was provided empathically and people were able to remember friends who had died and to reminisce about them.

Is the service well-led?

Good

The service was well led.

The registered manager was passionate about her role and supportive of staff. An open culture prevailed and staff were positive about working at the home.

Staff attended staff meetings and their suggestions were encouraged and listened to. The provider carried out annual surveys to obtain employee feedback.

People attended weekly house meetings and felt their views were acted upon. Relatives told us communication was good at the home and they were happy with the care provided.

Robust auditing systems were in place to monitor the quality of the care delivered overall.

The service worked in partnership with other agencies to ensure the best possible outcomes for people.

The Hollies

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.

The inspection took place on 23 November 2017 and was unannounced. The inspection team comprised an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had experience of people living with a learning disability.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the home and three relatives. We spoke with the registered manager and two care staff. We spent time observing the care and support that people received during the time of the inspection. We reviewed a range of records relating to people's care and how the home was managed. These included four care records and medicines records. We looked at staff training, support and employment records, audits, minutes of meetings with people and staff, complaints, policies and procedures and accident and incident reports.

Good

Is the service safe?

Our findings

At the last inspection undertaken on 13 September 2016, an area identified for improvement was the written guidance for 'as required' medicines. At this inspection we found that action had been taken to rectify the areas for improvement so that the rating has changed from Requires Improvement to Good. Medicines to be taken as required were prescribed for people and systems had been established so that staff had the information needed in the management of as required medicines. All staff were trained to administer medicines through e-learning and face to face training sessions; training was refreshed as needed on a regular basis. People who lived at 84 Barnham Road had secure medicine cupboards in their bedrooms. Medicines for people who lived at The Hollies were stored and administered from a medicines trolley located in the medicines room. We looked at a sample of Medication Administration Records (MAR) and these had been completed appropriately and confirmed that people had taken their medicines as prescribed. We saw an 'easy read' document had been obtained for one person so they could understand their health condition and how to manage it, with support from staff. An asthma monitoring form had been completed for another person in relation to the use of their inhaler. Medicines stocks were checked weekly and audits completed. When people left the home, for example, to spend time with relatives, their medicines were signed in and out by staff. Overall, medicines were ordered, stored, administered and managed safely.

People we spoke with told us they needed full support to take their medicines. The majority of people knew what times they needed to receive their medicines and why their medicines had been prescribed. A relative told us their family member reminded staff when they needed to administer their medicine and the three relatives we spoke with said that medicines were discussed as part of their review meetings with staff.

Systems had been established to protect people from potential abuse and neglect. All staff had completed safeguarding training. Where people had their own money or bank accounts, every transaction was accounted for and recorded to mitigate the risk of financial abuse. We asked a staff member what they would do if they suspected abuse had taken place. They explained, "If I was here I would go to a senior or manager or ring the 'on call' number, speak with the registered manager or a social worker. If people tell you something, you have to record exactly what was said. It would depend on what had happened as to what action I would take".

People we spoke with indicated they felt safe. One person said, "I feel safe most of the time, but I don't like it when other people are screaming and shouting. It gets on my nerves and hurts my ears". People said they knew what to do if they did not feel safe and they would talk to their family or the registered manager. Relatives told us they felt their family members were safe and that they could contact the registered manager if they needed to raise any concerns. A relative described how they had raised a concern relating to friction between another person and their family member and how this had been resolved. People said they felt they were treated equally and fairly, although one person told us, "Sometimes it's not fair that I can't do my washing when I want to". This was because people took turns to do their laundry so the washing machine might not be freely available if more than one person wanted to do their washing. Relatives felt that people were all treated as equals and one relative added, "The staff are all so kind and

caring to everyone".

Risks were identified, assessed, monitored and managed so that people were supported to stay safe and their freedom was respected. One person required 24 hour support and said they were able to most things with the support of staff. They explained that all the activities they were involved with were risk assessed and that they were involved in this. Some people went out independently and risk assessments had been completed to complement this. One person said, "I can go to the Co-op on my own, but that's all". Another person told us, "I can go to the village on my own". Where people went out independently they were aware of the risk assessments that had been completed and had contributed their views in the drawing up of these assessments. A relative was aware of the risk assessments in place and added they were happy about any restrictions imposed on their family member to keep them safe. They said their family member was, "Always out and about doing things". Where people's needs changed, for example, as they became older, risk assessments were reviewed and amended where necessary. Relatives were involved when risk assessments were reviewed. People told us they had the choice and freedom to do things they wanted to do and one person said, "I choose which games we play sometimes".

We looked at risk assessments contained within people's care records. These included assessments in relation to people's health conditions, mobility, bathing, cooking, security, medicines, falls, vehicles, co-tenants, staff, members of the public, going out alone, self-harm, verbal and physical challenging behaviour, inappropriate sexual behaviour and guidance for staff if people refused to take their medicines. One person with a particular health condition required their diet to be monitored and had their own file in the kitchen to record what they had eaten. Another person who required 24 hour support from staff had a device which monitored their pulse. Any increase in their pulse meant that a seizure was imminent, so detailed guidance was provided to staff on what action needed to be taken to protect the person from harm. Staff completed fire safety training and knew how to evacuate the buildings safely in the event of an emergency. Audits had been completed in relation to the environment such as water temperature monitoring and external contractors carried out checks on gas, electricity and water checks.

After the inspection, the registered manager emailed us the log of accidents and incidents which could not be easily located on the day of the inspection. The log recorded a brief description of what had occurred, the actions taken, who was involved and a later review which recorded any changes implemented as a result of each incident and any lessons learned. For each incident, it was identified whether the Duty of Candour applied. The Duty of Candour relates to the need for being open and honest with people and/or their relatives when things go wrong. An incident had occurred a few months ago when a person did not receive their medicines as prescribed. A safeguarding alert was raised and the incident was discussed with the person's relatives. Following the incident, lessons were learned and changes made to prevent a reoccurrence. We asked people whether they were involved in investigations or reviews in relation to their safety when things went wrong. We asked people if they had experience of the Duty of Candour regarding their care and treatment and whether communication was effective. One person said they had raised a concern and were happy with how it had been dealt with. Another person said, "I have complained about being bullied and I spoke to [named manager] and she sorted it out". A third person asked for their keyworker to be changed and this had been arranged. Two relatives said if they had any questions or concerns they would discuss these with the registered manager and they would be sorted out.

There were sufficient numbers of staff on duty to meet people's needs. Staff were allocated to each part of the home – a team at The Hollies and a team at 84 Barnham Road. A minimum of two support staff were on duty in each building during the day and one sleep-in member of staff in each building at night. One of these staff worked flexibly during the day and might also organise activities with people. When the registered manager was on duty, she could also provide additional support. In addition to these staff, one

person received funded 24 hour support. The registered manager told us there were always difficulties in recruiting new staff and that agency staff were sometimes needed to cover any gaps in shifts. A staff member commented, "There's never enough staff. We try and make time, but if someone's poorly or behaviours are raised, it can be difficult". Additional staff would come in when needed, such as for when people needed support to attend healthcare appointments. Staff were expected to cover a mixture of day and night shifts, although some staff preferred to work the night shift. The registered manager said, "There are very few incidents overnight. I can't remember the last time anything happened". We looked at four weeks of staff rotas and these confirmed the numbers of staff on duty as described above. People felt there were sufficient staff available to meet their needs. One person said, "If I have a fit, staff help me". Another person felt safe but added, "There's not always enough staff, but some people need more help than me". A third person told us, "If my 'alert' goes off, they come straight away". Relatives felt that staffing levels were good and told us that many staff had worked at the home for a number of years. One relative said, "Occasionally there are agency staff".

Safe recruitment systems had been established and staff records we looked at confirmed this. Before new staff commenced employment and were allowed to support people, their suitability to work in a care setting was vetted. Two references and checks were made with the Disclosure and Barring Service (DBS) and new staff's employment histories were examined.

People were protected by the prevention and control of infection. The home had recently been updated and refurbished and was clean and odour-free. Some flooring had been replaced with laminate, which made it easy to vacuum and keep clean. A relative said, "There have been amazing improvements in the decoration and upkeep of the building". People told us they felt the home was clean and three people cleaned their own rooms, with one person helping out with general cleaning. People were encouraged to be involved in housekeeping and we saw one person vacuuming the hall; they were enjoying the task and took pride in what they achieved. Weekly checks were made on people's rooms, with their permission, and to ensure that laundry was completed regularly.

Good

Is the service effective?

Our findings

At the last inspection undertaken on 13 September 2016, areas identified for improvement were that capacity assessments for people should be clearly recorded and staff should have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found that action had been taken to rectify the areas for improvement so that the rating has changed from Requires Improvement to Good.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Assessments had been drawn up that assessed people's capacity to make decisions in relation to specific areas such as managing money, going out and personal care. DoLS applications had been completed for people and the outcomes were still awaited from the local authority. Where decisions had been taken in people's best interests, these were clearly documented and the person who the decision related to had been involved. Where physical restraint might be necessary, for example, when people displayed behaviour perceived as challenging or were at risk of harming themselves, guidance had been drawn up to inform staff. We looked at a Restrictive Intervention Authorisation Checklist that had been completed for one person. This clearly identified the challenging behaviours and restrictive practice that could be used, which was prescribed medication. In addition behaviour monitoring charts were completed so that, as far as possible, challenging behaviour could be recognised and pre-empted, with restraint used as a last resort. All staff had completed mental capacity training and demonstrated their understanding of this when asked. People said they were fully involved in decisions about their care and their consent was always sought.

People's needs and choices were assessed so that their care, treatment and support was delivered effectively. People's care and support needs were evaluated and staff 'matched' with people, for example, where people and staff had similar interests. When activities were planned, people chose which member of staff they wanted to go out with. The registered manager said, "We reflect and are responsive to people's needs". People were encouraged to be as independent as possible and one person always took a mobile phone with them when they went out, to let staff know they were safe or if they needed to contact the home. People told us they were involved in the assessments of their care and care planning and were happy with the approach of staff to meet their individual needs. One person said, "I have some one-to-one time with staff".

In the Provider Information Return (PIR), we asked the registered manager how they kept up to date with good practice. They responded, 'United Response as an organisation, cascades information from quality

assurance departments at head office, through area management, to services. All members of staff have their own email and information is shared with all staff. This information is normally about good practice and changes in legislation as well as company updates. At The Hollies, this information is shared via email, team meetings and supervision meetings. Information is shared at all these meetings, including innovations in practice and opportunities to engage with others, and this is passed down to teams. The team access the local authority training as an approved provider. This gives opportunities to meet with people from other organisations and to share thoughts and practice. The organisation provides most of the staff training but courses bring staff from different services together, again with opportunities to share practice. The manager gets updates from West Sussex Learning and Development about training and forums. She attends the forums which update changes in procedures and practice. This is then passed down to the team. The manager also receives information from Skills for Care and British Institute of Learning Disabilities (BILD)'.

Staff had the skills, knowledge and experience they needed to deliver effective care and support. All staff had completed training in dementia, equality and diversity, fire safety, food hygiene, health and safety, medication, mental capacity, moving and handling and safeguarding. In addition, staff had completed training in epilepsy, first aid, person-centred support and autism awareness. Staff could study for vocational qualifications in health and social care with the majority achieving a National Vocational Qualification in health and social care at Level 2. We looked at the training plan and at certificates which staff had achieved in these areas of training. Staff spoke positively about the training they had completed and felt it provided them with the information they needed to provide effective care. Staff received supervision every six weeks and these meetings were opportunities to discuss their training and personal development, work related issues and any personal matters. For example, a record of a supervision meeting we looked at showed that people were discussed, staff, health and safety, policies and procedures, CQC, training and development. Four people told us they liked the staff who supported them. One person said, "I like all of the staff" and relatives we spoke with said they were happy with the staff and felt they had the skills to support people effectively. Another person told us, "Staff help me to shower and I am happy with how they do it".

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. One person had a health condition which meant that a low-carb diet would be beneficial and food was prepared for them to take account of this. People helped in meal preparation and with food shopping. One person said, "I love helping with the food shopping" and another person told us, "I don't always like everything, but I am very fussy". Everyone we spoke with said they had a choice of what they wanted to eat and that they were involved in menu planning. One person said they could make tea or coffee whenever they liked and added, "I can have fruit between meals". Another person said, "Staff help me cut my food". A relative explained that their family member had no teeth, so they were given a soft diet. We sat with people in the dining room and chatted with them as they ate their lunchtime meal. Staff ate their lunch with people too and the atmosphere was convivial, with lots of chat and interest evident between people and staff. People helped themselves to fresh fruit which was on the dining room table.

The service worked with a variety of organisations to deliver effective care, support and treatment. For example, one person's health had deteriorated recently and was a cause of concern, but the person refused medical treatment. Staff had supported the person to visit their GP, but the process had been gradual, to alleviate the anxiety this person experienced as they did not like any sort of medical intervention. The initial visit to the medical practice was organised and the person said 'hello' to healthcare staff. Gradually, as the person's confidence increased and their anxiety lessened, they were able to see the GP and also had support from their psychologist to help them with their anxieties. People we spoke with, and relatives, felt that staff worked well with each other and said staff understood their needs.

People had access to a range of healthcare professionals and services. Care records contained detailed

information about people's medical and health needs and a separate medical file contained details about prescribed medicines, healthcare appointments and any actions needed. We looked at one medical file which showed the involvement of the person with their optician, dentist, psychiatrist, chiropodist, speech therapist and community nurse. Care passports had been completed for people which contained information about their health needs in an accessible format, making it easy for the person to understand what had been written about them. People confirmed they had routine appointments with their GP, dentist and optician. One person said, "I have just seen the emergency dentist as I broke my plate and it was fixed the same day". Relatives told us they were happy that their family members' needs were met in this regard.

People's rooms were decorated in line with their preferences and we were shown several bedrooms, with people's permission. Rooms were personalised with people's belongings and items of interest to them and decorated with their favourite colours. There were plans to convert one spare room into a quiet space and to provide sensory equipment. In a kitchen at The Hollies, a work surface was lowered to make it easier for one person, who was short. Communal areas were spacious and accessible and people had access to gardens around the home. People indicated they liked having the garden for games or for sitting outside in nice weather. One person said, "I do a bit of gardening". People felt that the home was comfortable and suitable to meet their needs. One person said, "I like having my own toilet". Another person had their own chair in the lounge.

Good

Is the service caring?

Our findings

From our observations, caring and kind friendships had been developed between people and staff. People's views were listened to and we witnessed conversations that were friendly, supportive and infused with humour. People were at ease with staff and this was particularly evident since some people were anxious or confused about the inspection process; staff were reassuring and kind with them. People told us that staff were caring when supporting them and relatives confirmed that staff were always kind and caring. One relative said, "[Named family member] always goes back with a smile after being at home, so I know she is happy and well cared for". Another relative told us, "The staff go above and beyond for the people they care for". A third relative commented, "It feels like a big family". People felt that staff know how they liked things to be done and the routines of their daily lives. People also told us that their communication needs were met and that pictures were provided to aid them with their understanding. One person said, "I am dyslexic so I sometimes need help". People explained that staff were caring and thoughtful if they were upset or in pain. One person said, "Sometimes I talk to staff and sometimes I like to be on my own". Another person told us, "If I have pain I tell the staff and I get painkillers". People were encouraged to stay in touch with their families. One person enjoyed writing letters and wrote to staff when they were off sick or were no longer employed by the service.

We looked at whether people's communication needs were taken account of and how staff sought accessible ways to communicate with people in relation to decision making. People were involved in decisions relating to their care and people we spoke with confirmed their participation with this. One person indicated that they sometimes used pictures to make their needs known to staff. A second person preferred to communicate with written notes and this was how they had a conversation with us. They also used an iPad to help with communication and a tablet for drawing. A third person told us, "My sister comes to my reviews".

Throughout our inspection, we saw that people were treated with dignity and respect and their independence was promoted. One person said, "I go to my room when I want to be private". Another person said, "I like to help in the kitchen". Staff supported people in a discreet manner and encouraged people to be as independent as possible, for example, in relation to completing personal care.

Good

Is the service responsive?

Our findings

At the last inspection undertaken on 13 September 2016, an area identified for improvement was that people's care had not always been planned and reviewed with them or their relatives to ensure it met their needs. At this inspection we found that action had been taken to rectify the areas for improvement and that the rating has changed from Requires Improvement to Good.

Relatives told us they attended regular reviews relating to their family members' care and two relatives explained they took up the role of an advocate. One relative had asked for a full medication review for their family member which had resulted in some positive changes being made. A relative had emailed the provider and written, 'Many thanks for the detailed document you prepared for us and whilst the family are always kept well informed of [named family member] health and wellbeing, it was good to sit down and discuss matters in more in depth'. In one person's care record, we read about their end of month review. This showed what the person had been doing that month, for example, the contact with family and friends, going out, what was good and what had not worked so well, being at home, medical and personal care needs. Goals were set each month which were drawn up with the person's agreement by staff. There was information about what the person was looking forward to. The review was signed by the person it related to. This person sat with us in the dining room and looked through their medical file and care plan. From our observations, it was clear that they were familiar with the content of these plans as they showed them to us.

People received personalised care that was responsive to their needs. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Care plans were written in an accessible format and, where they were able, people signed their care plans to show their agreement. At the front of each care plan there was a one page profile which recorded, 'What people like and admire about me', 'What's important to me' and 'How to support me well'. People's personal histories were recorded and there was information in relation to their spiritual and cultural needs. One person went to church every Sunday and met with friends from church for coffee during the week.

Care plans we looked at recorded people's personal care needs, day and night routines, gong out into the community, work and volunteering, food preparation and dietary needs, medicines, activities and community connections. Each person had a planner which showed the structure of each day and what they liked to do. One person enjoyed multi-sensory sessions with perfumed candles, lights and massage; this helped them to relax. Where people had behaviours that could be perceived as challenging, there were detailed information and guidance for staff in how to manage this, for example, with 'talk-down' techniques or steps to follow to de-escalate negative behaviour. We saw one person's positive behaviour support plan which included 'setting events', triggers, behaviour, pro-active strategies, reactive strategies and the use of medicines to be taken if needed. One person would ask staff if they wanted medicine to help them calm down. One staff member said people could be upset when activities were planned, but might not always take place. They explained, "Agency staff are great, but they don't know people's foibles. If things are planned, we try and make sure these happen". This staff member talked about the lack of funding in

relation to providing additional staff when people wanted to engage with activities in the community or with extra support when people became upset. The staff member said, "Most behaviours can be headed off if you have enough staff".

People pursued individual activities that they helped plan and were of interest to them. Two people accessed daytime activities at a charitable trust situated close-by. People went to the local shops in the village, either with staff or alone. A staff member said, "Everyone in the community knows them". People had access to public transport and could, where assessed as safe to do so, travel independently on the train or the bus. We looked at other activities people were involved with such as woodwork, reading and writing classes, walks and a local club. People and relatives said they were happy with the activities on offer.

People's concerns and complaints were listened to and the complaints policy was written in an accessible format for people to understand easily. We looked at the log of complaints which recorded complaints from people on a range of issues. Each complaint was dealt with to the satisfaction of the complainant. For example, one person did not like their keyworker, so they were changed. People told us they knew how to raise a concern and two people said issues they had reported had been dealt with. One person said, "We have residents' meetings where we talk about things that are bothering us".

People had helped to fundraise for a cancer charity as a way of coming to terms with the death of one person from cancer. Two people told us about friends from the home who had passed away. People talked with us about one person who had passed away and were positive about the way they were cared for. People did not appear to be too upset and they were supported by staff to deal with these deaths; they were encouraged to talk about their thoughts and feelings. One person's death was expected and the other person had died unexpectedly in hospital. Bereavement counselling was arranged for one person who struggled to come to terms with their close friend's passing. Wakes were held at the home and candles were lit as people talked and remembered the people who had died. A senior area manager of the provider stated, 'I am writing to express my thanks and gratitude to you and everyone on the team for planning and leading on such a person-centred funeral. Knowing how [named person] felt about tractors, having one outside the crematorium was a wonderful idea as was the tractor floral arrangement'. Relatives of this person also sent a, 'Big thank you for all your efforts'. People's end of life wishes were recorded in their care plans when they were ready to discuss this topic.

In the Provider Information Return (PIR), the registered manager stated, 'As the people we support at The Hollies are getting older we need to be more proactive about end of life plans. It has not been possible to complete these plans for everyone, however work has started with two individuals. This will be completed this year for all the people we support. The communication review, which is to be undertaken for all the people we support, may identify different ways of presenting the issues around end of life and the team will make use of any advice given'.

Good

Is the service well-led?

Our findings

The values of the provider are shown on their website which states, 'United Response supports people with learning disabilities or mental health needs to take control of their lives and fulfil their individual needs, preferences and aspirations. We respect and promote the rights of every person we support. We support people to achieve the family relationships they want. We will do all that we can to enable the people we support to maintain positive and constructive relationships with family members and others important to them'.

The registered manager was passionate about her role and of ensuring that people who lived at the service had meaningful and worthwhile lives. The registered manager was involved in all aspects of the home, supported staff and knew people well. The culture of both parts of the home was person-centred, open and inclusive and staff we spoke with were positive about working there. One staff member told us that the registered manager was always supportive and had made adjustments to their working pattern following an absence from work. We asked the registered manager about their understanding of Duty of Candour and they explained, "It is about being clear and transparent and sharing information with people who need to know, making sure everyone is in the loop".

In the Provider Information Return (PIR), the registered manager stated, 'The manager at The Hollies believes that the best is brought out of teams with a positive, open culture where every member of the team feels valued and respected. She operates an open culture within the home for the people we support and the staff team. It is vital that staff are well trained and are given the resources to do their job well'. The registered manager operated an open-door policy and we observed staff freely seeking advice and support from the registered manager throughout our inspection.

In addition to receiving supervision from their line managers, staff attended staff meetings. These were held fortnightly on a Wednesday and from the minutes we looked at, staff were encouraged to make suggestions about the service to improve their practice and participate in the running of the home. We looked at a record of a staff meeting held in November 2017. Items discussed were shopping, budgets, Christmas, rotas and decorating the home. We talked with staff about their job satisfaction and whether they were happy in their roles. One staff member said, "It is satisfying to think you've made a difference. I'm here for the guys. I'm a team player and I love my job". The provider sent our 'employee engagement surveys' during 2017 to ascertain staff feedback about their employment.

People were involved in developing the service and house meetings were held every Sunday evening. Records showed that people were asked for their points of view and their comments were recorded in relation to suggestions or ideas, for example, in the planning of menus and food choices. People told us they met with their keyworkers on a regular basis and felt that they were able to express their views and opinions at house meetings. Relatives we spoke with were extremely happy with the communication from the home, both from the registered manager and staff. Relatives all referred to having built up relationships with the staff who had been there for some years. One relative expressed concern about the current registered manager who was retiring imminently; the relative told us she had brought her experience to the

home and made a lot of positive differences. Another relative had written, 'We can see that [named family member] continues to be very happy at Barnham and we really appreciate the care and support you always give her'.

Systems were in place to monitor and measure the quality of care delivered. We looked at quarterly audits in relation to a variety of areas including staff supervisions, people living at the home, health and safety, weekly medicines audits, fire, infection control, review of care plans, risk assessments including care delivery and premises, agency staff usage, observations of staff and environmental checks. Actions identified from the last audit were addressed to ensure that these had been completed. New actions from the current audit were identified. This helped to drive continuous improvement.

Notifications that the provider was required to send to us by law had been completed and sent to the Commission as needed. The Commission's rating of the home, awarded at the last inspection, were on display at the home and on the provider's website.

The service worked in partnership with other agencies, such as healthcare professionals and social care workers. The registered manager could ask for a reassessment of people's needs by a social worker, so that when people's needs changed, their funding package could be reviewed. In the PIR, the registered manager had written, 'During this year the team have worked with
psychiatry, psychology, community nurses and other external specialists to ensure the best possible outcomes for the people we support'.