Jemini Response Limited

Jemini Response Limited - 17 Jerome Close

Inspection report

17 Jerome Close
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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

About the service
Jemini Response Limited at 17 Jerome Close, Eastbourne, is a residential home providing personal care for up to three people. At the time of the inspection there were three people living at the service. People living at 17 Jerome Close were younger adults with learning disabilities, who had lived there since they were teenagers.

17 Jerome Close is a house in a residential area and had two floors. Bedrooms were on both floors and on the ground floor there was also communal living areas and an office. The home had a rear garden with a large, heated, outhouse that was used by staff and people.

The service has been developed and designed in line the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
The outcomes for people using the service reflected the principles of Registering the Right Support by promoting choice, control, independence and inclusion. People's support focussed on them having opportunities to maintain relationships, engage in activities of their choice and maintain their independence.

People were not able to tell us they felt safe however we observed staff interacting with people and spoke to staff about their understanding of safety issues, for example safeguarding. Relatives and professionals told us that they felt the service was safe. Staff knew people well and knew their care and support needs. Risk assessments were in place, specific to people's needs. Staff were recruited safely and there were enough staff working each shift to meet people's needs. There was a comprehensive induction process. Medicines were ordered, stored, provided and disposed of safely.

People were supported to have maximum choice and control in their lives and staff supported them in the least restrictive way and in their best interests. Staff had received training that was relevant to help them support people. This included mental capacity, challenging behaviour and safeguarding. People's nutritional needs were met and people were offered choice. People received support from health and social care professionals.

Staff were attentive to people's needs and were caring. People's privacy, dignity and independence were respected and promoted. People's differences under the Equalities Act 2000 were considered and respected.

Support received was person-centred and focussed on individual needs. Care plans were regularly reviewed with people, relatives, staff and professionals. People had routines which were important to them and a range of activities both inside and outside the home were provided. Strong links with the local community had been established. A robust complaints process was in place.

The registered manager was well thought of and staff, relatives and professionals told us they thought the home was well led. People reacted in a positive way with the registered manager who was a visible presence throughout the home. Audit processes were in place and were overseen by the registered manager. Feedback was sought from people, staff, relatives and professionals. Regular staff meetings were held.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people. The service used positive behaviour support principles to support people in the least restrictive way. The home used some physical restraint only.

For more details, see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspectionThe last rating for this service was requires improvement with one breach of regulation. (Published December 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Jemini Response Limited - 17 Jerome Close

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Jemini Response at 17 Jerome Close is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report.

During the inspection-
People had complex communication and support needs. We spoke with and observed all three residents of 17 Jerome Close. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who found it difficult to talk to us. We spoke with nine members of staff including the provider, the registered manager, the deputy manager, four care staff and two administration staff.

We reviewed a range of records including two people's care plans and medication records. We looked at two staff files in relation to recruitment and supervision and a variety of records relating to the management of the service for example, policies, procedures and audit processes. We pathway tracked two people. This is where we check that the records for people match the support they receive from the service.

After the inspection
We continued to seek clarification from the registered manager to validate the evidence we found. We spoke to three relatives and three professionals who regularly visit the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● Staff had a good understanding of people's care and support needs and knew how to deal with risks. Safeguards were in place to protect people from abuse and harm. People could not tell us that they felt safe but we saw that people were happy at the home and in the company of staff. People smiled and used non-verbal communication to interact with staff. A relative told us, "They are very safe, very much so."
● Staff had received safeguarding training and had regular refresher training. Staff were able to describe situations that constituted safeguarding and were able to tell us the course of action they would then follow. A staff member told us, "I would speak to a senior member of staff, a manager or if necessary a manager in our neighbouring home. I could take it to the local authority if I needed to."
● The home had a whistleblowing policy and staff were aware of how and when to report issues they were not happy with. Whistleblowing allows staff to raise concerns with the appropriate authorities if they think they have seen something wrong. The policy protects the identity of the person reporting.

Assessing risk, safety monitoring and management

● Individual risks to people were identified, documented and regularly reviewed to ensure people were kept safe. Staff knew people well and were able to tell us about risk and what they did to protect people.
● Risk assessments had been completed for people and were reviewed regularly and according to people's needs. For example, following a period of illness a person's mobility had declined. A full mobility risk assessment had been completed and action had been taken to mitigate against reduced mobility, for example ramps had been installed at the front and rear of the home to enable level access.
● Risk assessments were comprehensive and were divided in to risks to people, staff and others. Each contained contingencies to consider for example, where a person becomes anxious they may start to move their arms around quickly. The assessment documented that a calm approach using non-verbal communication, distraction and removal of others from the room help to lesson anxiety. Staff confirmed that they knew these contingencies and how to safely reduce risk.
● Every care plan contained a section called 'positive behaviour support plan.' This included detail of people's history, childhood and upbringing and how this had contributed to shaping their character now and the care and support needs required. An example was a person that was not able to self soothe or to calm themselves when anxious. The plan provided details about how to support the person at these times by using items from a sensory bag that staff carried with them.
● The home had a risk reduction folder which contained certificates and documents relating to checks made on electricity, gas and plumbing. A maintenance job list was held on computer and tasks were given a priority status to be dealt with by the maintenance team. This system provided a simple audit tool which

highlighted recurring issues. For example, it was noticed that a light bulb kept blowing in a room which prompted an electrician being called to address an underlying issue.
● Fire safety checks were completed regularly and evacuation procedures were practised. Fire extinguishers and smoke alarms were tested. Staff received regular training in fire safety.
● Personal emergency evacuation plans (PEEPs) were in place and evidence was seen of these being reviewed and updated if people's mobility needs changed. PEEPs provided detail of the reassurance and support people would need in an emergency.

Staffing and recruitment

● Staff files showed us that staff had been recruited safely. Relevant checks had been completed before a person could start work at the home. For example, references, employment history and Disclosure and Baring Service (DBS) checks. DBS checks ensure that people had no previous convictions or cautions that would prevent them from working with children or adults.
● People living at the home always required a minimum of one to one support. There was a minimum of four staff on for every shift. The home had a sister home in the same road and staff worked across the two homes to cover sickness and leave. We were shown staff rotas confirming that all shifts for a month in advance had been covered. During the inspection we saw staff with people, responding to their needs.

Using medicines safely

● Procedures were in place for the safe ordering, storage, dispensing and disposal of medicines. We were shown several medicine administration records (MAR) charts during the inspection and all had been correctly completed showing the date, time and amount of each medicine given and the name and signature of the staff member involved.
● MAR charts were checked daily for errors, refusals or other issues and a detailed monthly audit was carried out. We were shown a four-week calendar where medicines were ordered, delivered and returns made, in a cyclical way.
● Reviews of medicines took place with medical professionals and were in line with the 'STOMP' campaign, (stopping the over medication of people with a learning disability, autism or both.)
● 'As and when required' (PRN) medicines were recorded on the same MAR charts but were subject to a separate protocol to ensure safe provision. No controlled medicines were currently being used.
● People's medicines were kept in locked cupboards in their rooms which ensured security and privacy. We were shown a bottle of liquid medicine that had not yet been opened. We were shown a place on the bottle to record the date when it was opened.
● Staff had been trained in the provision of medicines. A staff member told us, "We have medicine training followed by competency training." Competency training is where staff were observed administering medicines by a senior staff member. Competency training was regularly reviewed.
● People rarely refused their medicine but staff knew that in the event of a refusal they should try again later or try with another staff member. Staff explained to people that the medicine was to keep them well.

Preventing and controlling infection

● The home was clean and tidy throughout including the kitchen. Staff had received infection control training and personal protection equipment (PPE), such as gloves and aprons were available and used when necessary.
● People's personal care and hygiene needs were recorded as part of care plans. People were encouraged to look after their own needs but staff were always available to help if needed. A staff member said, "They do

most of their personal care themselves but we sometimes step in to help them."
● We were shown certificates confirming the regular testing of water throughout the home to prevent legionella disease.

Learning lessons when things go wrong

● Accidents and incidents were recorded and outcomes analysed. The registered manager told us that they involved family and professionals when incidents happened and that risk assessments were consequently reviewed.
● Regular care team meetings were held at the home where staff and visiting professionals got together and reviewed people's needs and any issues arising. We observed a care team meeting. It was very detailed and specific actions that would support the person's ongoing care and support needs were recorded.
● The registered manager told us about a recurring incident involving a person discarding food and other items on the floor in the kitchen. This had created problems with cleanliness and staff had not been able to come up with a solution. A care team meeting was held and a simple solution devised which involved re-locating the kitchen bin so that it was within reach of the person.
● The registered manager chaired the care team meetings and had good oversight of all accidents and incidents. We attended a care team meeting and the meeting concluded by making an opportunity list and a task list. Based upon working recently with people these lists informed staff to know what to look for, what people enjoyed doing and helped people carry out tasks that were useful and enjoyable to them.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had lived at the home for several years. Before a person moves to the home the registered manager carries out an assessment of care and support needs with the person, family and professionals which forms the basis of the care plan.
● People's needs are reviewed regularly. There are monthly reviews and when a person's needs changed. For example, a person's mobility had declined and a review meeting took place to discuss the changing needs of the person.
● Care and support was provided in line with current legislation and guidance.

Staff support: induction, training, skills and experience

● We met a staff member currently in the first few days of their induction and were told about the initial training, familiarisation and shadowing opportunities provided. All staff confirmed that they received a comprehensive induction. A staff member told us, "It lasted several weeks and involved training, shadowing and beginning to get to know people. We also did Price training." Price training involves how to manage challenging behaviour.
● Following induction staff received regular supervision meetings with the registered manager. A staff member said, "It was every two weeks when I first started but now supervisions are once a month." They went on to say, "I can raise whatever issues I want but apart from shift changes I've never had to raise any concerns."
● The staff training plan is held on computer. We were shown how this clearly showed where people had training approaching and the registered manager was given a list each month to ensure all staff were up to date. The plan showed that staff had completed a variety of relevant training including, mental capacity and challenging behaviour, safeguarding, first aid and medicines. Specific key worker and management training were also shown..

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to maintain their nutritional and hydration needs. People were offered choice at mealtimes and drinks and snacks were available throughout the day.
● We observed mealtimes during the inspection. Staff would sit with people and sometimes have their meals with them. A pleasant atmosphere was observed at mealtimes with staff interacting with people. A staff member talked about what activities they had planned for the rest of the day and the person smiled.

● People had a weekly routine of helping in the kitchen. Staff rotated food preparation responsibilities and most days people would help. This helped people decide what food they would like to prepare.
● Care plans had detail of people's likes and dislikes and staff knew these preferences well. Nutritional risk assessments had been completed which helped to identify if people were at risk of malnutrition or dehydration.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Care plans contained a health action plan. This document provided details of people's health and social care needs and dates of appointments with professionals. For example, people had regular dentist appointments to maintain good oral health. The document accompanied people when they had appointments and provided staff and professionals with an overview of people's history and current needs.
● The registered manager had a positive relationship with professionals including GP's, physiotherapists and the community learning disability team. A professional told us, "The management are really good. They are proactive and responsive to the needs of clients and to us."

Adapting service, design, decoration to meet people's needs

● The home comprised of two floors. Each floor had bathroom and toilet access. Most of the ground floor had been adapted to meet the needs of people using wheelchairs. A ramp had been built at the front and rear of the premises. People were able to enjoy a garden area and a safe out house building where they could sit and listen to music.
● We were shown people's bedroom and each was decorated and furnished according to what people wanted. Each bedroom had pictures on the walls that had been chosen by people.
● People living at the home could not verbally communicate or read more than a few words. Around the home we saw pictures next to words indicating items, contents of cupboards or rooms. We saw people use these prompts as they moved around the home.

Ensuring consent to care and treatment in line with law and guidance

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met.

● Staff had received training in and understood mental capacity and how it applied to people living at the

home. A staff member said, "Communication is key to understanding. Sometimes they can indicate 'yes' or 'no' but some will indicate what they think you want to hear." Another staff member told us, "He knows when it's time to wash. He will indicate if he wants a bath by moving towards the bath and raising a foot."

● A professional told us, "Staff have a good understanding of the mental capacity act, their needs are always addressed."

● Staff understood the importance of obtaining consent from people. A staff member said, "I'll always ask whatever the task. If it's refused but it's in their best interest I'll try again later. Sometimes we ask family to help, another time they may respond to a different member of staff."

● People could make daily choices about food and drinks that they wanted. They could indicate how they wanted to wash each day and what clothes they would like to wear. We saw staff helping people with these decisions by offering choice.

● Mental capacity assessments had been completed for people and were decision specific. Assessments were grouped together under subjects for example, well-being. This area was then broken down into specific decision areas.

● People were involved in decision making and we saw documents giving detail of a conversation with a person about understanding why the outside front door was kept locked. The conversation took place using symbols and clear words and emphasised the need for safety. The conversation concluded that the person had not understood and this led to a best interest decision being made.

● Best interest meetings were held involving staff, relatives and professionals where people could not make decisions themselves. These decisions were documented and reviewed regularly.

● Staff had completed deprivation of liberty safeguard (DoLs) training. People can only be deprived of their liberty or otherwise have restrictions placed on their lives with the appropriate legal authority. DoLs had been granted for locking doors for example and ensuring that people were accompanied when out of the home on trips or visits.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People were not able to tell us that staff were caring but we observed positive interactions between people and staff. A relative told us, "They are definitely well cared for here." We saw a member of staff enter a room and speak to a person saying, "I'm working with you later today." The person put her arms in the air and smiled.
● Staff were with people all the time and supported them and were understanding to their needs. We saw staff sitting with people during mealtimes, talking to them about food and what they had planned for the rest of the day. We saw a person walking around the home becoming anxious and beginning to shout. Staff spoke calmly with them, repeating their name calmly and the person calmed.
● The registered manager knew people well. He spoke verbally and used Makaton, with all the people living at the home and they all responded in a positive way by smiling and holding their arms out to him. Makaton is a non-verbal means of communication using signs and symbols.
● Staff treated people fairly and equally and had a good understanding of equality and diversity. Everyone was supported and afforded time to move around the home as they wished. People were able to have their bedrooms as they wanted, decorated with personal items and things that were important to them.
● People were supported to maintain their spiritual and religious choices. Staff said they would take people to services if they wanted to attend or arrange for them to receive spiritual/religious support at the home. People's protected characteristics under the Equalities Act 2000 were considered and respected.

Supporting people to express their views and be involved in making decisions about their care

● Evidence was seen of people, relatives, staff and professionals being involved in care planning and reviews. The care plans had a section called 'circle of support' which listed everyone important to the person and who could contribute to the care plan. A relative told us, "We've had talks around care planning, I meet with them regularly."
● The registered manager told us that during care planning reviews a 'consultancy form' was used that listed those involved. These forms were placed on care plans and were referred to at subsequent reviews. A staff member said, "We work closely with parents on all aspects of care planning."
● Care plans gave details of what people wanted and needed. One person who lives with a language processing delay liked a quiet time at the start of their day with minimal talking. This was respected by staff.
● Confidentiality was respected by staff. Documents containing personal information were kept in a locked office. A meeting room had been built in the garden which guaranteed privacy during handover meetings

and any meeting where people were discussed. A staff member told us, "We're very careful especially in open areas like the smoking area in the garden. We'll not take phone calls about people in communal areas."

Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and independence were respected and promoted by staff. A staff member said, "I make sure people can use the bathroom alone. I'll always wait outside for them and help if needed." A person preferred not to wear many clothes when in their bedroom. This was respected by staff who were careful to facilitate this where the person was alone.
● People were given privacy during personal care. A staff member said, "We always make sure just one of us helps with personal care, it's only fair to protect their privacy as much as possible."
● A professional spoke about dignity at the home, "The staff are really good at promoting people's needs. They are always helpful and respectful to them and to us." A person had been unwell the day before the inspection and staff were talking about whether they would be able to go out that day. They spoke to each other and to the person about what they, the person, needed for the day and whether they were happy to be out for a few hours.
● People were encouraged to be as independent as possible. This included personal tasks such as dressing, washing and eating. A staff member told us, "We use Makaton and speak to people and say, 'do you need help?' They say yes or no and we help if they want us to."
● People were supported to help around the home with cleaning and cooking for example. After breakfast we saw a person helping to sweep up crumbs from under the table. They were encouraged and supported in this task but appeared to enjoy the responsibility. A staff member said, "We've moved away from set times for tasks and activities and now allow time for people to finish what they're doing, it's more effective and better for people too."
● People went out most days, supported by staff. Sometimes this involved a walk to the local shops or a trip out in a car. A staff member said, "People have their own flow. We manage them between us and understand that people present differently each day and we may need to change the planner."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans were person centred and focused on people's care and support needs, preferences and routines. At the last inspection care plans were found to be bulky documents containing out of date and inaccurate information. Risk assessments were similarly out of date, containing information that was no longer relevant. At this inspection the registered manager had made significant improvements. Care plans and risk assessments had been updated and were available to view in slim files that contained all relevant and important information.
● A lot of data and information was now stored electronically. We were shown this system which was easy to use and held up to date information.
● Staff knew people well and understood their care and support needs and the levels of support provided by family and the support required from professionals.
● People had their own key workers who were staff members who had a specific role with the care and support of the person. However, we were told that as the home is small, everyone helps. A staff member said, "I have a key worker role but all staff help and get involved. It works well." Another staff member said, "As a key worker I oversee everything. I write reports, contribute to risk assessments and manage their finances."
● The registered manager explained that people had lived at the home since they were young adults and that the staff had adapted to varying care and support needs as people had grown older. The registered manager said, "I want this to be a home for life." A relative told us, "(the person) has the care plan they need. I'd like them to stay there for ever. I hope they will."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs varied and no one could communicate verbally. People and staff used Makaton as the main source of communication and we observed questions being asked and yes or no answers being indicated.
● We saw staff sitting with people, sometimes quietly without speaking and at other times talking with them.

Interactions appeared to meet people's needs. We saw a staff member talking to a person about their sister's pets, knowing that the person liked animals. The person smiled and laughed and appeared happy.
● Some visual aids were also used. Picture exchange communication system (PECS) was used. For example, one person responded to being shown pictures of an apron and a kitchen, which meant it was their turn to help with food preparation. A picture of car keys indicated a trip out in the car and a 'now and next' book indicated they were going on a trip to the shops.
● People used different non-verbal signs that were recognised by staff. For example, one person found it difficult to indicate they were in pain. They may point for example, to their teeth, if they had toothache but this would not always happen. Staff knew when people were in pain as they became anxious and agitated. At these times other professionals such as GP's or the community learning disability team would be called. Another person was known to rub their forehead when they wanted attention.
● People's care plans had details of the support they required with communication and how to reassure people when they became anxious.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were involved in activities at the home and on trips out that promoted their wellbeing. We saw people getting ready to go out. They were happy and helping to get themselves ready. The registered manager said, "A good house is an empty house." Meaning that people were out, taking part in activities.
● People had their own weekly activity planner that involved recreational activities and domestic tasks that they were encouraged to help with. One person's planner had the following: walk to shops; out for lunch; feed ducks; recycling and clean the inside of the car.
● A variety of activities were available at the home. A staff member told us, "There is a good range every day, depending on the person. We ask them what they would like to do, it might be arts and crafts or maybe baking." They said, "If they say no, we'll offer again a bit later."
● People were seen enjoying activities in the home. One person enjoyed talking with staff and several conversations were seen. They discussed what toiletries they needed and what they would buy at the shops later that day. They talked about where they would go for a drink when they were out. Another person spent time listening to music through their headphones. They enjoyed this and were seen swaying to the music and smiling.
● People enjoyed regular visits and contact from their families. We were told that everyone had a visit from family at least once each week and that families were supportive of the them and the home. A relative told us, "I visit regularly. They (person) has grown in stature since they've been there. The staff are always so welcoming."
● The registered manager told us about the importance of routine for people and that they did not like change or anything presented differently within the home. He explained that they recognised and celebrated festivals such as Halloween and Christmas but were careful not to decorate the home excessively. He said that the presence of a Christmas tree can cause anxiety to people.

Improving care quality in response to complaints or concerns

● The home had a complaints policy that was accessible and outlined a clear process for when issues were raised. Although people could not communicate verbally staff knew them well and were able to tell if they were not happy about something. Relatives of people were closely involved with the home. A relative told us, "We discuss issues all of the time but I've never had to complain. Another relative said, "There are always things to discuss but nothing serious and things are always resolved quickly."
● No serious complaints had been raised recently and therefore no data was available from which to draw

any conclusions about practice. We were told about the process if a serious complaint were to be raised, an investigating officer would be appointed from their neighbouring home. A written report would be submitted and a decision maker, a manager, would determine the outcome.

● We were shown a minor complaints book. All issues raised had been dealt with quickly and the original complainant contacted with the outcome and an apology if appropriate. Historically complaints had been received about parking. The registered manager had resolved this by producing a map showing staff where they could park.

End of life care and support

● People living at the home were young and no one was in receipt of end of life care. The registered manager had acknowledged the importance of discussing with relatives plans for future care. An end of life policy had been written and end of life plans were now included within care plans. These were at an early stage and had not been fully completed at the time of the inspection. There were plans to introduce end of life training for staff.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated Requires Improvement with a breach of regulation. At this inspection, improvements had been made, they provider was meeting the regulation and the rating has now improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● At the last inspection care plans were found to be inaccurate or out of date with sections about behavioural support missing. Reviews had not been completed, the correct procedure for complaints had not been followed and there had been no recent fire drills. All these issues had now been rectified.
● At the last inspection issues were found with administering medicine. Open dates had not been recorded on liquid medicines. Although at the time of the current inspection no one was receiving liquid medicines, staff were able to tell us the correct procedure and where to record open dates.
● At the last inspection protocols for pain relief did not refer staff to the Disability Distress Assessment Tools (Dis DAT). DisDAT are used to document signs and behaviour of people who might be in pain who cannot verbally communicate. At this inspection we were shown DisDAT forms for people and staff were able to tell us the signs they look for to assess if a person is in pain.
● We were shown processes for auditing. The registered manager reviewed records regularly including staff training, accidents and incidents, medicine records including MAR charts and complaints. The home has two sister homes that are also managed by the same registered manager. He told us that he managed auditing across the three homes and looked for good practice that could be shared.
● Staff understood their roles and responsibilities. For example, staff managed their own training programme and were responsible for being up to date. This was monitored by the registered manager through quality assurance checks.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager knew people well. During the inspection we observed several interactions between the registered manager and people. He communicated with them by talking to them and using Makaton and everyone responded to him in a positive way. People smiled and communicated with the registered manager and it was clear they were comfortable with him.
● We spoke to relatives about the registered manager. A relative told us, "It's very well run. If I was not happy I'd let them know." Another said, "He's brilliant, very understanding."
● Professionals also spoke well of the registered manager. A professional said, "The management are really good, always so helpful. I've only ever had positive experiences."

● Similarly, staff spoke highly of the registered manager. A staff member said, "I feel absolutely supported. I almost left at one stage but now feel very enthusiastic about the job." Another staff member told us, "I am confident to speak to the manager. I feel well supported."
● Care plans were person centred and a positive culture was promoted at the home. All staff, including the registered manager where friendly and interacted well with people. Staff were approachable and were seen to always respond to people's needs.
● Staff were kept up to date with any changes to routines or if people's needs changed. Handover meetings took place at every shift change and details were recorded in a handover binder. Regular meetings were held to discuss individuals. These involved everyone involved in the person's daily care routine. Because the home was small, staff interacted and spoke with each other many times during any given shift.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager fully understood his responsibility under the duty of candour. He was open and honest with us throughout the inspection. Registered managers are legally obliged to inform CQC of significant events that happen at their homes and this had been complied with by the registered manager. The previous CQC rating for the home was displayed in a communal area of the home.
● Staff told us they felt confident to raise issues and to approach the registered manager if they needed to. They told us that the home had an honest and open culture. A staff member said, "There are formal and informal meetings and daily and weekly catch ups. If I ever have an issue I'll ask."
● Relatives told us that they felt informed about what was happening at the home. A relative said, "I see them regularly, I'm always kept up to date."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager sought feedback. Opportunities were given to staff to feedback about the home in a variety of ways. We saw feedback from staff questionnaires and evidence that issues and suggestions raised using this forum were listened to. For example, a suggestion was made to reward staff for good attendance. As a result, a policy was drawn up and put in place.
● The registered manager and staff told us that supervision meetings were also a good opportunity for staff to provide feedback. There were regular supervision meetings held but we were also told by a staff member, "If an important issue comes up I can ask for a supervision with short notice." Evidence was seen of additional sensory items being purchased because of staff feedback.
● The home is small and regular relatives' meetings were not held. However, the registered manager spoke with relatives every week and there were opportunities during visits for relatives to provide feedback. A relative said, "I meet the manager regularly. He always listens to us." Similarly, feedback was sought from professionals with any issues raised being addressed. A professional told us, "We speak to the manager regularly, he is very responsive."
● Good work and complimentary messages and e-mails were seen on staff files, recognising good work.
● Equality characteristics were recognised and discussed as part of care plan reviews.

Continuous learning and improving care

● The registered manager encouraged personal development of his staff and provided them with opportunities to take responsibility. In addition to the key worker roles he had created 'champion' posts. For example, a senior member of staff took responsibility for managing medicines, under the supervision of the

registered manager. A role had also been created for a sensory champion who took the lead on developing new ways of soothing and communicating.

● The registered manager had written a continuous improvement policy and evidence was seen of how the home had developed. For example, level access to the front and rear of the premises because of a person's mobility issues. An occupational therapist had recommended, to help improve mobility and flexibility, that a ballet handrail and mirror were installed in a person's bedroom. This had been done and the person enjoyed using them and their mobility had improved. The registered manager explained that feedback from staff was fed into the improvement plan.

● The registered manager attended a variety of forums and support groups for managers. He sought support for the home from the local authority and Health Assured Employee Assistance. The latter is a support group for staff and managers who provide coaching to help staff achieve a positive work life balance. The registered manager kept up to date with latest developments in care by regularly visiting the local authority and CQC websites.

Working in partnership with others

● Jemini Response has had two homes in the same road for several years and are an established part of the local community. People had established a place in the local community and were well known to local people, shops and businesses. The registered manager told us, "We have built bridges over the years, we speak to local residents all of the time."

● The registered manager had forged strong working links with other services and professionals for example, GP's, community learning disability teams, dentists and occupational therapists. These links ensured people's heath and care needs were met and best practice maintained. A professional told us, "They are very good. They manage complex and challenging physical and social behaviour and they do it well."