# Dame Hannah Rogers Trust

# Arthur

## Inspection report

Stray Park
Park Street
Ivybridge
Devon
PL21 9DW

Tel: 01752898125

Date of inspection visit:
17 February 2016
23 February 2016

Date of publication:
23 March 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection took place on the 17 and 23 February 2016 and was unannounced.

The service provides care for people with a physical disability, and can provide care for up to seven people. When we inspected six people were living at the service.

The service had a registered manager 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.

The atmosphere in the home was calm and welcoming and people were observed to be happy in the company of staff. Relatives said they felt people were happy living at Arthur, one commented "The care is exceptional, the staff really care about people". Professionals we spoke with said they had observed lovely relationships and positive interactions between people and staff.

We saw people laughed and smiled as they were being assisted by staff. For example, with daily routines such as eating, drinking and when they were being supported with transfers prior to personal care or as they were getting ready to go out. People's responses and body language indicated they felt safe and comfortable with the staff supporting them.

There was a positive culture within the service. The management team provided good leadership and led by example. Staff were clear about the values of the service and spoke in a compassionate and caring way about the people they supported. Comments from staff included, "Our big responsibility is about encouraging people to make choices" and, "I feel very proud to work at Dame Hannah Rogers Trust, people have a good quality of life". The management team were organised and the service was well-run. People's risks were monitored and managed well. Accidents and safeguarding concerns were managed promptly. There were effective quality assurance systems in place. Incidents related to people's behaviour or well-being were appropriately recorded and analysed. Audits were conducted, action points noted and areas of the service improved where needed. Relatives and professionals said the management team were approachable and they did not have current concerns about the service.Staff received supervision, annual appraisals and training relevant to the needs of people they supported.

Staff supported people in a caring and compassionate way. When people showed signs of distress or feeling unwell staff responded promptly and sensitively to ensure they remained comfortable and happy. Staff included people in their conversations and were seen bending down to ensure people in wheelchairs were at eye level with them when talking. As staff moved around the home they knocked on doors and informed people of what they were doing. This demonstrated staff understood the importance of privacy, dignity and respect.

We saw staff were visible in the communal areas and responded instantly when people required assistance. Equipment to maintain people's safety was visible, close to them and well maintained. A range of specialised equipment was available to meet people's individual care needs and to keep them safe and comfortable.

Care records were personalised, and focused on people's current needs and wishes and encouraged people to maintain their independence where possible. Staff responded quickly to changes in people's needs. People and those who mattered to them were involved in identifying their needs and how they would like to be supported. People's preferences were sought and respected. People's life histories, disabilities and abilities were taken into account, communicated and recorded, so staff provided consistent personalised care, treatment and support.

Staff understood their role with regards to ensuring people's human rights and legal rights were respected. For example, the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) were understood by staff. All staff had undertaken training on safeguarding adults from abuse; they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

There were sufficient numbers of staff to meet people's need and to keep them safe. Systems were in place to regularly review staffing levels to ensure they remained appropriate. Staff had time to sit and spend time with people and this was considered as important as daily tasks and household chores. The provider had effective recruitment and selection procedures in place and carried out checks when they employed staff to make sure they were fit and safe to work with vulnerable people.

People had their medicines managed safely, and received their medicines in a way they chose and preferred. People were supported to maintain good health through regular check-ups and visits to the GP, dentist and opticians. People's health was closely monitored and any changes addressed as a matter of priority.

People were supported to have their dietary needs met. Risks in relation to eating and drinking were known and understood by staff. Where possible people were involved in choosing their meals and supported to eat as independently as possible; using specialist plates and cutlery when required.

People were encouraged to live active lives and were supported to participate in community life where possible. Activities and outings were meaningful and reflected people's interests, age and choice.

## 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. Relatives told us they felt people were well cared for and safe.

People were protected by staff who understood how to recognise and report possible signs of abuse and/or unsafe practice.

There were sufficient numbers of staff to meet people's needs and keep them safe.

People were protected by safe and appropriate systems for handling and administering medicines.

People were protected by safe and robust recruitment procedures.

### Is the service effective?

Good

The service was effective. People were supported by highly motivated and well trained staff.

People were assessed in line with the Mental Capacity Act 2005 as required. Staff respected people's rights, asked for their consent and waited for their response before providing support and treatment.

People's nutritional and hydration needs were met.

People had their health needs met and any concerns were addressed promptly.

### Is the service caring?

Good

The service was caring.

People were treated with respect by staff who were kind and compassionate.

Staff listened to people and encouraged them to express their views and be involved in their care.

People's privacy and dignity was respected and promoted.

## Is the service responsive?

Good

The service was responsive.

People had personalised support plans in place to reflect their current needs.

People were supported to lead a full and active life. People were actively encouraged to engage with the local community and to maintain relationships important to them.

People's concerns were listened to and any complaints were addressed.

## Is the service well-led?

Good

The service was well-led.

Staff, relatives and other agencies said the service was well-led.

There was a positive culture within the service. There were clear values that included involvement, compassion, respect and choice.

There was clear evidence of the provider ensuring the quality of the service. The registered manager and senior staff had audits in place to ensure the quality and safety of the service.

# Arthur

**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 the 17 and 23 February 2016 and was unannounced. The inspection was carried out by one inspector.

People who lived at Arthur had some communication difficulties and most were unable to communicate verbally about their experiences using the service. We spent time in the communal parts of the home observing people's daily routines and the interactions between them and the staff. Some people were able to communicate using their personalised communication aids. For example, one person was able to communicate using an electronic communication aid and with the use of a board consisting of familiar signs and symbols. Where possible staff supported us to spend time with people talking about their care and experiences of living at Arthur.

Prior to the inspection we reviewed the records held on the service. This included the provider information return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we met all of the people currently living in the service. We reviewed three care records in detail and spoke to people where we could. We observed how staff interacted with and supported people. We also spoke with seven staff and reviewed three personal and recruitment records. We were supported on the inspection by the team leader and the registered manager for the service.

We also reviewed a range of other records relating to people and the running of the service, such as records which related to the administration of medicines, accident and incident forms, minutes of meetings, policies and procedures and quality audit forms.

Following the inspection we spoke with three relatives and sought the views of a number of professionals who know the service well. We spoke with three health and social care professionals. This included an Occupational Therapist, a speech and language therapist and a Behavioural Advisor.

Good

# Is the service safe?

## Our findings

We observed people as they were being supported by staff. We saw people laughed and smiled as they were being assisted with daily routines such as eating, drinking and when they were being supported with transfers during personal care or as they were getting ready to go out. People's responses and body language indicated they felt safe and comfortable with the staff supporting them. Relatives we spoke with said they felt staff looked after people well and ensured they were safe.

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they felt reported signs of suspected abuse or poor practice would be taken seriously by the provider and dealt with appropriately. Staff had completed training in safeguarding adults and this had been regularly updated. The training helped ensure staff were kept up to date with any changes in legislation and good practice guidelines. Detailed policies and procedures were in place in relation to safeguarding and whistleblowing. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately.

People's finances were kept safe. People had appointees to manage their money where needed and this included family members. Where possible people were involved in decisions and discussions about their money. For example, one person's support plan stated, 'I need support with money, but involve me in all purchases and let me choose'. Money was kept securely and two staff signed money in and out. Receipts were kept where possible to enable a clear audit trail on incoming and outgoing expenditure and people's money was audited on a regular basis.

Risk assessments were in place to support people to live safely at the service. Assessments had been carried out to identify any risks to the person and to the staff supporting them. This included environmental risks as well as risks associated with their support needs and lifestyle choices. Assessments included information about any action needed to minimise the risk of any harm to the individual or others, whilst also promoting and recognising the person's rights and independence. For example, one person had a risk assessment in place for going out of the service. The plan included the risks associated with the person's mobility,health and the equipment required. Staffing levels and the support required to minimise these risks was also included. Another person had a risk assessment in place for an exercise activity, which involved the use of a trampoline. The assessment described the possible risks associated with this activity and how the person needed to be supported to benefit from the activity and remain safe. A risk management meeting was held each month with senior staff to review risks across the service and to consider any improvements and safeguards.

Personal Emergency Evacuation Plans (PEEPS) were in place and the provider had a clear contingency plan in place to ensure people were kept safe in the event of a fire or other emergency. Risk assessments were in place to ensure people were safe when moving around inside or outside the building. Regular checks were completed of equipment and vehicles to ensure they remained safe and fit for purpose.

There were sufficient numbers of staff available to meet people's needs safely. Staffing levels had been

organised for each person dependent on their assessed need. Support plans and risk assessments clearly described how these staffing levels were organised and the support required by the person concerned. Staff told us they felt there were enough staff on duty to enable them to meet people's needs safely. Comments included, "When I am on shift I haven't experienced any staffing problems, it feels safe and we have plenty of time to spend with people". The team leader confirmed they reviewed staffing numbers regularly and made changes when needed. For example, one person had been assessed as requiring an additional staff member to support with personal care tasks. Changes had been made for two staff members to provide support during this time and the changes had been documented as part of the person's risk assessment and support plan.

The home had safe recruitment practices in place. Required checks had been undertaken prior to staff starting work in the home. For example, disclosure and barring service (DBS) checks had been made to ensure staff were safe to work with vulnerable adults. The provider requested references from previous employees and prospective staff were invited to visit the home and undertake a formal interview process. New staff undertook a probationary period followed by an appraisal before a permanent position was offered. This helped ensure new staff understood their role and were suitable to work in the service.

People's medicines were managed safely. People's care records had detailed information regarding their medicines and how they needed and preferred these to be administered. Where possible people had a choice about how their medicines were given. For example, one person's support plan said they would sometimes like medicines on a spoon and other times in their food. We observed people as they were being supported to take their medicines. We saw staff talked to people about what they were doing and checked they were happy and comfortable throughout the process. One person found it particularly difficult to swallow, and became upset when medicines needed to be administered. Staff followed the guidelines to ensure the easiest and most appropriate administration methods were used. Staff also provided gentle words of reassurance to help the person concerned remain as comfortable and relaxed as possible. Staff told us they undertook training in the safe administration of medicines and this training was regularly updated.

Staff explained the process of ordering medicines and the checks completed when they arrived in the service. Each person's medicines file had a photograph of the individual as well as a brief description of the medicines prescribed, dosage, reason for taking and possible side effects. Medicines Administration Records (MARS) were in place and had been correctly completed. To reduce the risks of errors two staff members were responsible for administering medicines, one signed the MAR to confirm the medicine had been given and the other completed a second witness signature.

Medicine cabinets and fridge temperatures were monitored daily and a record kept to ensure the temperature was in the correct range. Information was clearly available for staff about people who required, as needed (PRN) medicines. These protocols helped ensure staff understood the reasons for these medicines and when and how they should be given. Clear direction was given to staff on the precise area prescribed creams should be placed and how often. Staff kept a clear record to show creams were administered as prescribed.

Good

# Is the service effective?

## Our findings

People received care and support from staff who knew them well and who had the skills and training to meet their needs. There was a strong emphasis on training and continued professional development. Staff confirmed they undertook a thorough induction when they first started working in the home, comments included, "The induction was good, I shadowed experienced staff and had time to complete initial training and read important records".

Records confirmed all new care staff undertook an induction when they started to work at the service. In addition to shadowing and reading records new staff completed a set of compulsory training modules specific to the service and their role. The registered manager had started to introduce the new Care Certificate as part of the induction process. The Care Certificate is a new national set of standards for all staff new to care.

Records and certificates of training showed a wide range of learning opportunities were provided for all staff. Systems were in place to ensure all staff undertook training identified by the provider as mandatory subjects, such as Equality and Diversity, Health and Safety, Safeguarding and Food Hygiene. In addition, an on-going training plan was in place specific to the needs of people the service supported. This included training in, communication, eating and drinking, continence care and behaviour management. Training was provided by therapists employed by the organisation as well as external agencies such as the local authority specialist community teams. Comments from staff included, "There is so much training compared to my previous job and, it is actually relevant to the people we support",and, "We are always learning, no two people are the same, the training is really good, especially the eating and drinking and manual handling".

Staff said they felt well supported by their colleagues and management. They said they received regular supervision and comments included, "We have regular supervision, it is an opportunity to ask questions and discuss our role". Team meetings were held to provide staff with the opportunity to reflect on practice, highlight areas where support was needed, and encourage ideas on how the service could improve.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and team leader understood their responsibilities under the MCA and had attended relevant training. The MCA provides a legal framework for making particular decisions of people who 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 the mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. Records and discussion demonstrated people were supported to make choices but where they lacked capacity staff ensured their care was discussed with a range of professionals, relatives and independent advocacy when appropriate. This helped ensure decisions about people's care and lifestyle were made in their best interests.

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). The registered manager told us they had liaised with the local authority when it was felt they could be restricting a person of their liberty and had applied for DoLS on behalf of people. At the time of the inspection these applications were awaiting review by the local authority designated officer.

People's consent was sought before care and support was provided. We saw staff asking people if they were happy for them to provide support, such as administering medicines and assisting with personal care. Staff gave people time to consider what they had said and waited to see their response to judge if the person was happy with the support being offered. For example, we saw staff ask one person if they were happy to be moved to a different chair where they felt the person would be more comfortable. The staff member waited for the person to respond and recognised their smile was a sign of them accepting the support being offered.

Staff were supported to understand and manage people's behaviours in an appropriate and lawful manner. Behaviour management plans were in place for some people to help staff understand the behaviour people may present, to recognise the triggers and signs and understand the action they would need to take if the behaviour occurred. We observed staff responding when people grabbed other people's clothing and table cloths during the lunchtime meal. The staff responded gently and with humour ensuring minimal disruption and making sure everyone remained safe and happy. The provider had sought advice from external agencies in relation to people's behaviours when required.

People had their nutritional and hydration needs met in a personalised way. All of the people who used the service needed support to eat and drink. Support plans detailed people's specific needs in relation to eating and drinking and risks had been assessed with plans in place to ensure people remained safe. One person's plan stated, 'I don't use words but can communicate through facial expressions, I will drop my spoon when I have had enough'. Staff we spoke with were very familiar with this information. Staff sat with people each week and used photographs to help people make choices about meals and to plan the menu. People's specific likes and dislikes had been documented as part of their individual support plan.

We saw people were able to enjoy their meals within a relaxing and unrushed environment. When possible people were encouraged to eat independently with the close supervision of staff to ensure their safety. People who required special cutlery, plates and special seating had this provided and staff were aware of each person's needs in relation to their diet and mealtimes. Each person had a laminated meal plan on the dining room table, which reminded staff about people's specific needs, such as the environment needed when eating, special equipment and how food should be prepared. All the staff we spoke with said they had training in eating and drinking and were very familiar with people's individual guidelines. Staff looked for creative ways to make sure people had enough to eat and drink. For example, one person was reluctant to eat their lunchtime meal. Staff were aware of the person's particular like of sweet food and food with texture and crunch. The staff considered healthy ways of adding these tastes and textures and were eventually successful in encouraging the person to finish their meal. People's food and fluid intake was carefully monitored and recorded and any concerns were acted on promptly.

People were supported to maintain good health and when required had access to a range of healthcare professionals. Support plans included information about people's past and current health needs and staff were familiar with this information. Information had been documented as part of a 'hospital passport', which could be used should a person require admission to hospital. This information is considered by the National Health Service to be good practice to help ensure people's needs are understood should they require treatment in hospital or other healthcare facility. Records detailed people saw their GP, specialist

nurse, optician and dentist as required. Any advice from professionals was clearly recorded and linked to people's care plan for continuity of care and treatment. People's general health was monitored and staff responded promptly to any sudden changes or concerns. For example, one person was very distressed due to experiencing pain. Although staff were aware this was due to a known and on-going condition the staff responded promptly by ensuring the person was as comfortable as possible and contacted the GP for an emergency appointment.

People's individual needs were met by the adaptation, design and decoration of the service. The service had been divided into two separate areas with each side providing facilities for three people. Each side had its own kitchen, dining area, bathrooms and individual bedrooms. The home was spacious, with good access for wheelchairs and other equipment. People's bedrooms had been decorated attractively, and contained equipment and personal items that reflected their needs, interests and age. For example, one person due to their mobility needed furnishings and personal belongings to be placed within easy reach. We saw their bedroom had been organised with photographs, notice boards and mirrors at a low level. The staff member supporting them said this it was really important for this person's personal space to be organised in this way. Sensory equipment was available in the communal areas as well as bathrooms and bedrooms to provide stimulation or a relaxing atmosphere when needed. The garden area was accessible and designed in a way that could be used safely by people during the summer months.

Good

# Is the service caring?

## Our findings

The atmosphere in the home was calm and welcoming and people were observed to be happy in the company of staff. Relatives said they felt people were happy living at Arthur, and comments included, "The care is exceptional, the staff really care about people". Professionals we spoke with said they had observed some really lovely relationships and positive interactions between people and staff.

Staff spoke in a way that demonstrated they really knew people they supported. They were able to tell us about people's likes and dislikes, their daily routines and how they preferred to be supported. Staff provided routines that were personalised. For example, we saw some people liked to relax during the morning and have their breakfast in an unrushed manner, others were ready and keen for staff to support them with their daily routine and planned activities. One person liked to relax on the sofa for an afternoon sleep. Staff provided this and had covered them with a soft blanket and they looked very cosy and relaxed. Another person was keen to talk about plans they had for the future. Staff showed genuine interest in this person's plans and there was plenty of lively and excited conversation.

We heard staff talking to people on a one to one basis and also encouraging conversation and interaction between people and staff. It was noted when staff spoke to each other they included people in their discussions and ensured people were aware of what was happening. Staff ensured people's wheelchairs and seating were positioned so they could see and be involved in what was happening. Staff sat with people and ensured they were at eye level so when they spoke people could see their facial expressions. Staff spoke to people in a way that made them feel extra special. For example, we heard staff saying, "You look so lovely today" and, "You have done so well". These interactions made people laugh and smile and helped create a relaxing, happy environment where people clearly felt included and part of the home.

People were supported by staff when they felt unwell or needed emotional support. One person communicated to staff about their emotions and feeling sad. The staff listened and offered kind and reassuring words of support. They told the person concerned it was alright to feel sad and talked with them about ways they could feel better. Another person was distressed due to pain associated with a long standing health condition. We saw two staff spend thirty minutes supporting the person to feel comfortable and relaxed. The staff offered the person alternative seating and provided a range of aids to assist them to relieve pain and pressure. The staff spoke to the person concerned saying, "Is that better?", "Would you like your head higher or lower?",and, "Would you like a pillow under your head". We saw the staff stayed with the person until they started to relax and smile and continued to check they were comfortable as they rested.

All the staff talked about people they were looking after with passion and care. One staff member said, "I love working with […] she is so lovely and such great fun to be with". One person said they felt, "fantastic" today. The staff member supporting them replied, "I feel fantastic too, because when you feel fantastic I do too". This response clearly pleased the person concerned and made them laugh and smile.

Staff supported people to express their views and where possible to be actively involved in decisions about their care. One person had expressed a wish to move from the service to a more independent setting. The

staff had supported the person by involving other agencies and helping them plan visits and consider how they might achieve their goal.

We saw staff spoke to people as they provided support and observed their responses as a way of knowing if the person was happy or if they had a view on the care being provided. People's privacy and dignity was promoted and respected. Throughout the inspection we saw staff knocked on doors before entering. As staff went from one part of the home to another they spoke to people and explained why they were walking through their personal space. For example, we saw one staff member bend down so they were at the person's eye level and say they hoped it was alright as they were going through their sitting room to collect some items for another person. We saw staff were discreet when delivering personal care and allowed people time on their own, whilst ensuring they remained safe and happy. We observed offers of care in communal areas were sensitive and staff spoke to people in a low voice about issues of a private nature.

Good

# Is the service responsive?

## Our findings

Relatives said they believed people were happy living at Arthur and their needs were well met. One person used their communication aid to tell us they were happy living at Arthur.

People received consistent, personalised care, treatment and support. People's support plans included clear and detailed information about people's health and social care needs. Each area of the plan described the person's skills and the support needed from the staff or other agencies. For example, one person had regular input from the local district nursing team and this support was clearly detailed as part of their overall plan. Another plan detailed a person's support provided by the occupational therapy services in relation to continence care.

How people wanted their care delivered was clearly documented in people's support plans. For example, one plan described a person's personal care needs and stated how they needed to be supported to make choices about their clothing and preferred to have a bath in the morning. A staff member said, "It is really important for people to have consistent care, staff who know them".

Support plans provided staff with clear information about risks and specific guidelines to follow when providing care and support. For example, one plan indicated risks in relation to eating and drinking and included a clear eating and drinking assessment and guidelines for staff. Another plan advised staff of the need to read the person's behaviour management guidelines to help them recognise, understand and manage behaviours that could occur.

Staff said most people had limited capacity and skills to understand and partake in the planning of their care. However, where possible they included people and spoke to them about their care and support. We heard staff talking to people as they supported them and checking they were happy with the support being provided. One person was able to communicate using personalised communication aids. Records and discussion confirmed they had been involved in discussions and planning about their care and lifestyle choices.

People were supported by staff to communicate using a range of tools and communication methods. Staff were familiar with people's communication methods and had undertaken relevant training.The service was able to access support and advice from speech and language therapists employed by the organisation and also made referrals, when required, to external agencies. People had detailed communication profiles describing how they communicated and a range of tools to support them. For example, one person communicated using an electronic speaker and a board with a range of familiar pictures and symbols. Another person was supported to use a picture exchange system (PECS) to communicate their needs and make choices. The keyworker for this person showed us their PECS folder and an example of how they would show them a picture of their riding hat to communicate it was the day they went horse-riding.

Records showed staff responded to a range of needs as they arose. We saw staff responding promptly and sensitively to people's needs. Relatives said staff kept them up to date and would call if there was an issue

they needed to know about. Staff had followed advice from occupational therapy services and introduced an egg-timer system for one person to help them understand when activities started and finished. Staff said this had been really successful and had helped reduce the person's anxiety.

Systems were in place to help ensure information about people's needs were regularly reviewed and updated. Each person had a designated keyworker who had a special interest in the person they supported and was responsible for ensuring support plans remained appropriate and up to date. One keyworker we spoke to said monitoring records and meetings had identified how a person they had supported was sleeping more frequently during the day. A plan had been agreed as part of these meetings to support the person concerned to be more active and to access a greater range of community activities. People had access to independent advocacy services when required to help them make decisions and discuss their care.

People were supported to maintain their links and develop new ones with the local community. Arthur is situated within the small town of Ivybridge and people regularly attended community events at local schools, colleges and churches. One staff member said, "I think Arthur and Dame Hannah Rogers are quite unique, everyone in the community knows people and welcomes them at events".

People were supported to lead a full and active lifestyle. People made choices about their routines and how to occupy their time and activities were relevant to their age and personal interests. Throughout the inspection we saw people coming and going from the home. Staffing was organised so that people could go out when they wanted and we saw poor weather conditions and other events in the home didn't stop people getting on with the things they wanted to do. The organisation provided a range of activities on its main site, which was within walking distance of the home. The notice board had information about some of these activities such as, pet therapy, yoga and music sessions. One person arrived back from a pet therapy session and smiled when the staff member supporting them talked about the rabbits and mice they had seen. We saw some people went off for the day on shopping trips and to eat out and others went for a stroll into the nearby shops to get some small items of shopping. One person went with their keyworker to the Plymouth Aquarium, a place of interest the staff said they particularly enjoyed.

People were supported to develop and maintain contacts with family and friends. Support plans included information about important contacts and any specific arrangements for maintaining these relationships. For example, one person had a 'Facebook' account on their IPAD and used this to maintain regular contact with family. Another person went home each week and staff assisted with these plans when required. One staff member told us about their plans to support a person during their family holiday. They said, "It will be really nice, I will meet the family first and then go with them to provide support so they can have the family holiday they wanted".

The service had a complaints policy and procedure in place with information about how people could complain if they were not happy with the quality of the service. We saw this information was available in an easy read format within the head office of the main site. However, this information was not available for people, relatives or visitors to access at Arthur. We discussed this with the registered manager at the time of the inspection. On the second day of our visit information about the complaints process as well as easy read information had been posted on the notice board within the service.

Good

# Is the service well-led?

## Our findings

Relatives said they felt the service was well-led and they were kept informed about important issues. Professionals said they felt there had been improvements in the leadership of the home and this had benefited the people living there. Comments included, "There is a more consistent staff team, which has resulted in better and more consistent care", and "The team leader is really good, she is a good role model for new staff".

There was a positive culture within the home and staff were very clear about their values and responsibilities. They spoke with commitment and used words like, 'individual', and 'personal' when they talked about people they supported. One staff member said, "Our big responsibility is about encouraging people to make choices" and, "I feel very proud to work at Dame Hannah Rogers Trust; people have a good quality of life".

There was a registered manager employed to manage the service locally. The registered manager was also registered with the CQC to manage two other service run by the organisation. There was also a senior management team to oversee the governance and leadership of the service. The registered manager was based on the main site of the trust, which was within walking distance of the home and was supported by two deputy managers. They visited the home regularly and had a good knowledge of the people and staff. The day-to-day running of the service was overseen by a senior staff member who was based at Arthur and worked as part of the care team.

Staff confirmed they were able to raise concerns and agreed any concerns raised would be taken seriously and dealt with. Staff had a good understanding of their roles and responsibilities and said they were well supported by the senior management team. Comments included, "The team leader is really good, we can go to her for anything" and, "I have regular supervision from the […] (deputy manager) and can contact the management at any time".

The registered manager and management team maintained their own professional development by attending regular training and keeping up to date with best practice. For example, the registered manager had recently attended safeguarding and MCA training and was undertaking a degree in health and social care. They had also attended various provider forums, which included a recent meeting in London with other providers and representatives from the Care Quality Commission (CQC). This was passed onto staff as required to help them also remain up to date.

Information was used to aid learning and drive improvement across the service. We saw incident forms had been completed These were detailed  and included a section for staff to consider any learning or practice issues. Accident and incident reports were sent to the head office and analysed to look for any trends developing or where any preventative action needed to be taken.

The registered manager and management team continued to explore ways to improve and develop the service. For example, it had been felt a previous management structure had not been working effectively. A

review had taken place of the structure and management roles and changes made to ensure improvement. The registered manager was also in the process of reviewing daily monitoring forms with a view to introducing new systems, which they said would provide clearer evidence of people's needs being met by the service. The registered manager showed us a 'Compliance improvement plan' for the year, which included the introduction of the new care certificate, and risk management meeting to ensure an oversight of risk across the service.

Where possible people were involved in decisions about the service. One person as part of their support arrangements had developed a 'Guide to a good day'. This information was specific to the person concerned but was being looked at with the person to roll out across the service as a way of further ensuring people received the service they needed and expected. Consideration was also being given to how people could be more involved in the running of the service and service user forums were being developed as part of this process.

Staff meetings were held to provide opportunity for open communication. Daily handover meetings helped ensure staff had accurate and up to date information about people's needs and other important information.

It was clear from records held within the service that the registered manager and other senior staff took an active role in auditing and assessing the quality of the service. As well as seeking feedback from staff and relatives a number of regular audits took place including, an infection control audit, audit of medicines, records and people's personal finances. Systems were in place to ensure the building and equipment were safely maintained. Essential checks such as water temperatures and fire safety equipment also took place.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events, which occurred in line with legal obligations and kept relevant agencies informed of incidents and significant events as they occurred.

The registered manager had introduced a policy in respect of the Duty Of Candour (DoC) and understood their responsibilities. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct.