Voyage 1 Limited

109 Grange Road

Inspection report

109 Grange Road
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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

This inspection took place on 19 January 2018 and was an unannounced visit. At the last inspection carried out in August 2015 we found that the provider was meeting all of the legal requirements set out by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and those associated with their registration and was rated as 'Good'. At this inspection, we found that the provider continued to provide a good standard of care to people.

109 Grange Road 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 care home comprises of one purpose built building which is registered to accommodate up to five people who require personal care and support associated with their learning disabilities. At the time of our inspection, there were five people living at the home. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post at the time of our inspection. '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.'

Everyone we spoke with without exception, were extremely positive about the management of the service. Relatives and staff we spoke with reported the registered manager to be approachable and supportive in their leadership style.

Systems and processes in place to monitor the safety and quality of the service included the involvement of people, relatives and other stakeholders. The provider ensured that information was available in different formats to meet the needs of people and promoted their involvement in providing feedback on the care and support they received. Relatives we spoke with knew how to complain and were confident that any concerns they rose would be dealt with efficiently and effectively.

We found that people were protected from the risk of abuse and avoidable harm because safeguarding systems and processes were in place and implemented effectively. People were supported by sufficient numbers of staff who had the knowledge and the skills they required to care for people safely and effectively.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, reviewed and monitored. This ensured

that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff, to ensure that care was person-centred and any decisions made in respect of their care and support needs, were done so within their best interests and in accordance with the Mental Capacity Act 2005. Where people were assessed to lack the capacity to consent to the support they received, the provider had followed key processes to ensure that care was provided in the least restrictive ways possible. Applications had been made and authorisations received to safeguard people against the unlawful deprivation of their liberty, where necessary. People's privacy, dignity and independence were respected at all times.

Quality assurance practices within the home ensured that the maintenance of the premises and equipment within the home were monitored for their function, safety and cleanliness. We saw that the property had been adapted to ensure people were supported to remain safe within a homely environment. Staff were also aware of risks to people when supporting them outside of the home in order to promote people's safety within the community.

People received support from staff to take their prescribed medicines as and when required. Systems and processes were in place to ensure medicines were managed safely and only senior members of staff who had undergone specific training and supervision were permitted to administer medicines within the home.

Staff sought the expertise of specialist services and health and social care professionals to ensure that the care they provided to people was in keeping with legislation and best practice guidelines. This included advice and support specific to learning disabilities, autistic spectrum disorders and any associated physical health symptoms such as epilepsy and dysphagia (swallowing difficulties).

People were supported to maintain a healthy diet and all health needs were met with the support from staff. It was evident that people had developed positive relationships with staff and there was a friendly, calm, relaxed atmosphere within the home. Staff knew people's likes, dislikes and preferences well and supported them to engage in activities of interest. People lived active and fulfilling lives and were supported to maintain and develop relationships with their relatives and friends. Visitors were always made to feel welcome.

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.

People were supported by enough members of staff, who had been safely recruited, to ensure that they were kept safe and their needs were met.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People received care and support with their consent, where possible and people's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care from staff who had received training and had the knowledge and skills they required to do their job safely and effectively.

People's nutritional needs were assessed and they were supported to eat food that they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals, when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, helpful, friendly and caring. This caring approach was also extended to relatives and friends.

People received the care they wanted based on their personal

preferences, likes and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People and their relatives felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were encouraged and supported to engage in activities that were meaningful to them.

People were supported to maintain positive relationships with their families and friends.

People and those closest to them were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Good

The service was well-led.

Staff felt supported within their roles and reported the registered manager to be approachable with an 'open-door policy'. This was also confirmed by relatives spoken with.

The provider had systems and processes in place to continuously monitor the safety and quality of the service which were implemented effectively.

Conditions of the provider's registration were met, including the reporting and notification of significant events.

109 Grange Road

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 19 January 2018 and was a routine unannounced inspection. The inspection was facilitated by one inspector. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We looked at the information that we hold about the service prior to visiting the home. This included statutory notifications from the provider that they are required to send to us by law about events that occur at the home, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we spoke or spent time with five of the people who lived at the home. We also spoke with two people's relatives. We spoke with four members of staff including the registered manager, a team leader, and two support workers. Some of the people living at the home had complex care needs and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also made general observations around the home and reviewed the care records of two people to see how their care was planned. We also looked at the medicine administration processes within the home. We reviewed training records for staff and looked at two staff files to check the provider's recruitment processes. We also looked at records which supported the provider to monitor the quality, safety and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Good

Is the service safe?

Our findings

Everyone we spoke with was confident that people were protected against the risks of abuse and avoidable harm. A Relative we spoke with told us that they felt assured that people were kept safe living at the home. They said, "Safe? Oh, yes, she is most definitely safe there [home]". Another relative told us, "I have no concerns at all; I know [person] is safe and well cared for". Staff we spoke with confirmed that they had received training and knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "It's our job to keep people safe; if I was concerned about anything at all I would go straight to [registered manager], write it all down with a timeline of events if necessary". They went on to tell us that staff had access to contact numbers for external agencies such as the local authority or CQC if they were concerned that things were not being dealt with effectively by the provider. This was also confirmed by other staff members we spoke with and observations we made within the mangers office, which included information posters with the relevant external agencies contact details. We also saw that people looked relaxed and comfortable in the presence of staff and sought staff company and affection. Records showed that staff had received safeguarding training. The registered manager and the team leader were aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that any safeguarding concerns that had been raised had been reported to the relevant agencies and had been investigated thoroughly with appropriate action taken.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, reviewed and monitored. This ensured that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff, to ensure that any risk management and care plans were person-centred and that any decisions made were done so lawfully and in keeping with best practice guidance. Staff we spoke with were familiar with people's individual care needs and any health related risks, such as epilepsy or specialist dietary needs. For example, one member of staff showed us an epilepsy protocol that had been devised to ensure staff knew what action to take in the event of a person having a seizure including when and how to administer the necessary medicine. A relative we spoke with told us they were confident that staff had the skills to keep people safe in this way. They said, "They [staff] are all very good and let me know if [person] has had a seizure and what support they have given to her". All of the staff we spoke with were aware of people who had specialist dietary needs and the associated risks of choking. One member of staff told us, "Some [people] have dysphagia which means they can't swallow properly and are at risk of choking. We have to ensure their food and fluid is the right consistency for them which are outlined by the SALT (Speech and Language Therapist)". Staff spoken with knew what to do in the event of a person choking and records we looked at showed that staff were trained in emergency first aid. Records we looked at corresponded with the information staff told us about people's risks. Risk assessments and care plans were accurate, complete, legible and regularly reviewed and updated to ensure that staff had all of the information they needed to support people to stay safe.

Staff were we spoke with were also able to tell us what action they would take in other emergency situations, such as in the event of a fire. One member of staff said, "People have different needs, some can

walk independently, others need our assistance. In the event of a fire, we [staff] would be allocated to support people to evacuate the building by the necessary means, either guiding them out or using the fire sledges". Records we looked at showed that people had Personal Emergency Evacuation Plans (PEEP) and the provider's fire safety systems (such as the fire alarms, fire extinguishers, fire doors) were serviced and monitored regularly to ensure they were in good working order. The registered manager told us, "We have always maintained good fire safety but since the Grenfell Tower fire, we [provider] have reviewed and revised all of our fire safety practices including practicing full evacuations". This showed that the provider took a proactive approach to learning lessons when things had gone wrong either within or outside of their organisation.

Another example to demonstrate that lessons were learned within the service was in relation to medicines. Information we hold showed that an incident had occurred within the home by way of a missed medicine. The team leader told us that this had occurred due to a lack of communication between staff within the home. Upon review of this incident, staff were instructed to make effective use of the communication book and staff we spoke with confirmed that this book is used as part of the shift hand-over process and is the first point of reference when starting a shift.

We checked the medicine systems and processes within the home and found that people received their medicines as prescribed. We saw staff supported all of the people living at the home to take their medicines. We saw medications were stored appropriately and staff were aware of the disposal policy for unwanted or refused medication. Processes were in place to identify missed medication early and there was a good rapport between the provider, GP and pharmacy to ensure people received their medication as prescribed. We also found that the provider had recently taken the 'STOMP Pledge' to Stop over Medication of People with a learning disability, Autism or both. We saw medication reviews were held with the GP and any other prescribing clinicians to ensure medicines were monitored closely. Some people were prescribed medicines on an 'as required' basis, for example for pain relief. We saw that protocols were in place to support staff to administer these safely. Some of these protocols included generic terms such as 'for pain relief'. They would have benefitted from additional person-specific detail to ensure that staff were aware of what specific signs and symptoms people may present with to indicate that they were experiencing 'pain' and required these medicines. This was acknowledged by the registered manager who informed us that this information would be added without delay.

Everyone we spoke with and observations we made showed that people were supported by sufficient numbers of skilled staff that were deployed effectively to ensure people received the care and support they required. One relative said, "There are always enough staff around". We saw that shifts were organised so that a shift leader and sufficient support workers were allocated daily duties. This meant that people received the support they required and any additional duties such as cooking and cleaning were adhered to without impacting upon the support provided to people.

We checked two staff files to check that the provider was adhering to safe recruitment practices. We found that the provider had ensured that all pre-employment checks had been completed prior to the staff starting work. These included identify checks, previous employment references and criminal history checks via the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions and prevents unsuitable people from working with people who require care. Staff we spoke with confirmed that all of these checks had been completed before they had starting working with people and that they had an opportunity to shadow experienced staff before working independently. One member of staff said, "It was a very efficient and happened very quickly but was also a very thorough process. They [provider] made sure my references and DBS were back and I had all of the relevant safety training and shadowing; I felt a bit like a spare part initially but I and they [provider] wanted to make sure I knew what I was doing and was

confident before I started working with people on my own".

We saw that the property was maintained and clean. Records we looked at showed that regular infection control and maintenance checks were carried out; where any actions were required, these were followed up. For example, we saw that some of the flooring in people's en-suite facilities required replacing. The registered manager showed us that this had been identified as part of their environmental checks and records we looked at confirmed that the provider had sourced an external company to provide a costing quote for this work. We also noticed that the stair lift was faulty during the inspection and we later observed maintenance personnel visiting the service to identify and diagnose the issue. This did not impact on the access of people within the service because there was also a functional lift in situ, but the registered manager explained that the stair lift was a useful 'back-up'.

Staff we spoke with were aware of the infection control practices within the home and we observed them adhering to this throughout our visit. For example, we saw staff washing their hands regularly and wearing protective clothing where necessary. Health and safety checks within the home were also carried out to protect people from such risks for example, legionella and fire safety.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were being cared for in the least restrictive ways possible. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and authorised. Staff were aware of these authorisations and supported people in the least restrictive ways possible. There was a system in place to support the management team to ensure that where further applications were required; these were applied for in a timely manner.

Records we looked at showed that people and those closest to them, and/or involved in their care had been involved in decisions relating to their care and support needs and, where necessary best interests' decisions had been recorded comprehensively. It was evident that there was a clear understanding of the principles and practices of the MCA within the service. Observations we made within the home showed us that staff were working in accordance with the MCA. We saw staff engaged with people in ways that they could understand in order to gain consent and to promote independence and choice as much as reasonably possible. One relative we spoke with said, "They [staff] are brilliant with [person]; [person] can be difficult to engage in this way but they never give up trying. They involve her in making decisions and choices as much as possible, like taking her out to buy clothes and choosing the colour of paint for her room". We saw that information was presented to people in different ways such as pictorial formats or objects of reference (the use of objects to visually represent an item, activity, place or person) to enable people to engage and promote their involvement in making day to day decisions and choices.

We saw staff offered people choices about what they wanted to do, where they wanted to spend time, and what they had to eat and drink. One member of staff told us, "We support people to make choices by showing them options, like two jumpers and seeing which one they point to or by using picture cards; they can all definitely tell us what they want or don't want! We get to know people well enough to know how best to communicate with them and read their body language or signs". Another member of staff gave us an example of how a person made a choice about what they wanted to eat. They said, "Earlier, I offered [person] a choice of two snacks, raisons or crisps. She pushed the raisons away so I knew she wanted the crisps! We know she would never opt for the healthy option [laughed] but we make sure she gets the choice".

Everyone we spoke with, observations we made and records we looked at showed that staff had the

knowledge and skills they required to do their jobs. One relative told us, "The staff are simply excellent; they all know what they are doing, definitely very skilled and passionate about their work". Staff we spoke with told us that they received training to ensure they had the knowledge and the skills they required. We found that new members of staff engaged in an induction programme and staff we spoke with told us that this prepared them with the knowledge and skills they required to care for people safely and effectively. One member of staff said, "The induction was very good; it wasn't rushed and I didn't feel like I was thrown in at the deep end; I was given time to read and do my training, shadow other staff and get used to people and their needs. Everywhere is different and I felt very supported to learn what I needed to know here". We saw that staff training compliance was recorded on an electronic computer system which detailed the dates when staff had completed various training as well as a rolling programme of updates that staff were registered to undertake throughout the year. There was a comprehensive induction programme and new staff were supported and monitored throughout their probation period to ensure they had the knowledge and skills they required. We also found that staff received regular supervision meetings with either their team leaders or management which provided an opportunity to discuss learning and development opportunities. Staff we spoke with told us that the registered manager was visible within the home and would offer constructive feedback and praise following observations of their work. One member of staff told us, "[registered manager] is very good; I ask her if I am doing ok and she will tell me what I do well and areas I could improve on, which I think is great!". Records we looked at confirmed this.

We saw that people had a good choice about what they ate and they enjoyed the food staff prepared for them. A relative we spoke with told us that they were pleased with the meals that were prepared for their family member. They said, "Everything is excellent including the food". There were no set meal times at the home and people ate when they were hungry. One member of staff told us, "Because people all have their different routines, meal times are just planned in to people's days". We saw evidence of this during our inspection. We saw people were supported to eat what, when and where they preferred. Staff members took a lead in preparing the main evening meal which looked and smelt lovely and those that were able, assisted staff in the kitchen, in order to enhance their independence and daily living skills. We saw people were supported to eat by staff where required and people's specific dietary needs were catered for. Where a change in peoples dietary needs were identified, referrals were made to the necessary professionals. For example, during our visit, we saw the registered manager speaking with a dietician about a change in one person's weight and seeking the necessary advice. Other records we looked at showed that the provider had sought support from speech and language therapists (SALT) with regards to people's swallowing needs which can be addressed with specially prescribed diets. The registered manager told us, "When a person has had a change to their diet, we support their families to understand these changes to". They gave us an example of how they had recently requested a SALT speak with a person's family member about a specialist dietary requirement to ensure the person was supported to eat safely when they visited the family home as well as within the care home.

Relatives we spoke with confirmed that people were supported to maintain good health and to attend any medical appointments they were sent. One relative said, "They [staff] support her to attend any appointments, it's just what they do. They will let me know if there is an appointment coming up in case I want to go with too but this is never expected and it's never a problem if I can't, they will feedback to me anything I need to know". Records we looked at showed that all medical appointments were recorded and people were supported to access an annual health check including, a 'well woman' health check. We found that people had access to doctors and other health and social care professionals as required, including specialist practitioners relating to their specific health conditions. We also saw that any health care concerns were followed up in a timely manner with referrals to the relevant services.

Good

Is the service caring?

Our findings

Everyone we spoke with and observations we made, all without exception, showed that people were treated with kindness, respect and compassion. One relative we spoke with told us, "The care here is exceptional. The staff are all so kind and caring". Another relative said, "I cannot fault any of them. They are all so kind and caring and that extends to us too". They gave an example of how their loved one had recently spent time in hospital and staff had gone to the hospital to visit the person, but also to 'relieve' the family so that they could go home to get some rest, whilst ensuring the person continued to have company from familiar faces. The relative we spoke with told us that this meant a great deal to them as they knew the staff cared for them and loved them like family. They said, "[person] is perfectly happy at the home and I know the staff love her and care for her in such a genuine way".

Throughout our time at the home staff spoke about people with genuine compassion and familiarity with many staff likening people they cared for to their own friends and family. One member of staff said, "I love my job and I enjoy spending time with the girls [people], it's such a pleasure".

We saw that people received both practical and emotional support from staff at all times and were treated as individuals. Staff we spoke with including new members of staff knew people extremely well and were able to tell us about different people's care needs, any associated risks as well as their hobbies, interests, likes, dislikes and preferences. We saw that people were supported to follow their hobbies and activity schedules were tailored to meet their interests and preferred routines. For example, people were supported to attend day centres, spend time with their families or enjoyed going out for local walks or engaging in relaxing baths and pampering activities. People were supported to maintain their individual differences in relation to their personal appearance and style preferences. One relative we spoke with said, "She always looks lovely, well presented and there is never any concern with her personal hygiene. Staff will take her shopping to pick clothes that she likes, so she maintains her own personal style and identity". We also saw that people's bedrooms were personalised and reflected them as individuals. The registered manager told us, "It is important people are involved in decisions about their personal space so that it is made to feel like their home". They gave an example of how two people had recently swapped rooms and despite both of the rooms being well-maintained and comfortable, requests had been made for maintenance personal to re-decorate the rooms in their own personal styles and preferences. Staff and relatives we spoke with and records we looked at confirmed that people were supported to make decisions and choices about the decoration of their room. One staff member said, "We will get colour charts, magazines, wallpaper samples and take people to the shops to choose their room designs".

People were involved in all aspects of their care as far as reasonably possible and were supported to make day to day choices because staff made every effort to communication with them in ways they could understand. We saw information was presented to people in various formats in accordance with their needs. Written information was available in was accompanied by pictorial illustrations to aid understanding. Verbal communication was consistently accompanied by gestural prompts or objects of reference to further support people's understanding of questions, choices and instruction. This collectively enabled people to be more involved and promoted their autonomy and independence within the home. One member of staff

said, "Just because people can't speak doesn't mean they can't communicate; we get to know people well enough to be able to 'read' their facial expressions, body language, gestures, moods; all of this helps us to understand and know what people want or need and give people choices".

People were treated with dignity and respect. We saw staff respected people's choices and autonomy within the home and spoke to people respectfully with kindness and compassion. Relatives we spoke with told us that this level of courtesy was extended to them also, and their input and relationships with their loved ones was valued. One relative said, "They [staff] are very respectful and understanding and help us too". Staff we spoke with gave us examples of how they protected people's privacy and dignity within the home. For example, we were told that personal care was provided to people in the privacy and comfort of their own rooms and staff ensured curtains and doors were closed at all times. One member of staff said, "I make sure that they [people] are covered as much as possible and talk to them throughout, so they know what I am doing and make sure they are okay with it".

Good

Is the service responsive?

Our findings

We saw that people were treated as individuals and their personal likes, dislikes, preferences and daily routines were respected and promoted. People and those that were closest to them alongside any relevant health and social care professionals were involved in the planning and review of their care, to ensure that care was specific to their individual needs, preferences and person-centred. One relative we spoke with said, "We have regular meetings to discuss any changes or how things are going; sometimes these are large meetings with myself, my husband, the registered manager and any other staff like [person's] key worker and professionals that have been involved in her care". We found that people were allocated a 'key worker'. A 'key worker' is a member of staff that has been identified as a consistent point of contact to support people with the planning and review of their care as well as any other assigned care tasks, specific to that person. This promoted consistency to further enhance the person-centred approach. Relatives and staff also told us that it supported communication and engagement between them as it fostered familiarity and helped them to build trusting relationships between people, relatives and staff.

Care records we looked at were comprehensively detailed and person-centred. They reflected what staff and relatives had told us and our observations throughout the day. We saw people engaged in activities that they had identified as meaningful and important to them and staff supported people to spend as much time as possible doing the things they enjoyed. We found that people benefitted from structured daily and weekly routines, which stimulated their minds and offered opportunities for social engagement. One relative said, "She [person] has a very active and fulfilling life". They went on to tell us about activities that their loved one enjoyed within the home such as cooking, as well as outside of the home including attending day centres, going shopping and visits to the cinema. We also heard about holidays and day trips that people were supported to enjoy. We saw people enjoying interactive and more passive activities within the home including story books, watching television and self-directed activity with objects of meaning. One member of staff said, "[person] loves anything made of plastic that makes a rustling noise like laminating film or plastic paper wallets used for filing". We saw this person enjoyed scrunching up these objects, listening to the sounds it made and laughing with enjoyment. Relatives we spoke with told us how staff were always enthusiastic and encouraging people to get involved in activities. One relative we spoke with said, "There is always something going on and she [person] is always getting involved, in fact she rules the roost I think [laughed]".

People were supported to maintain relationships with people that were important to them. Relatives we spoke with told us they were always made to feel welcome at the home and staff also supported people to visit their loved ones. One relative said, "They [staff] even drop her off and pick her up when she comes home to visit; it's brilliant". We saw relatives visiting the home on the day of our inspection and were greeted fondly by staff and other people living at the home. They said, "I like to come and take her out for a bit, she usually stays overnight with me and we go out for food and for a drive; she loves the car". They went on to tell us that the person is always happy to return to the care home which gave them assurance that she liked living there and was happy.

People and their loved ones were supported to make decisions related to their preferences and choices

about their end of life care. Records we looked at showed that staff had taken the time to discuss different choices, decisions and preferences that people had about the care and the arrangements they wanted at the end of their life. This information was presented in an easy-read and pictorial format, which detailed where people wanted to spend their final days, those they wanted involved and any advanced decisions or final wishes they would like to have respected. Funeral plans and arrangements were also documented, ensuring that person-centred care planning was maintained even after death.

Records we looked at showed that the provider had a compliments and complaints policy which they adhered to. Everyone we spoke with told us that they knew how to complain and they were confident that their concerns would be dealt with appropriately. We found that where complaints had been made, the provider had responded either in writing and/or had offered the opportunity to meet with those raising the complaint, to discuss their concerns. Improvement plans had been developed and action had been taken to work towards making their required improvements. Information we hold showed that any concerns that had been shared with us about the quality of the service being provided to people had been addressed and dealt with internally and appropriately. One relative we spoke with said, "Anything I have raised before has been dealt with immediately and properly; I have no hesitations to raise any issues with [registered manager] she is very approachable and very good. I know if she wasn't able to deal with it, she would have no problems with passing on contact details for yourselves [CQC] or any other appropriate agency".

Good

Is the service well-led?

Our findings

At our last inspection in August 2015, we found that some improvements were required to the management of the service. This was because systems and processes in place to monitor the quality and safety of the service were not always implemented effectively and the provider had failed to sustain a stable staffing team. Collectively, this had impacted upon the quality and consistency of care being delivered to people. During this inspection, we found improvements had been made to these areas and the provider had continued to monitor and develop the service in order to provide and sustain a good standard of care.

There was a registered manager in post at the time of our inspection. 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.'

Everyone we spoke with, without exception were complimentary of the management of the service. Comments we received included, "[Registered manager] is brilliant", "I cannot find any fault at all; anything we raise is dealt with immediately and professionally". Staff we spoke with told us that they felt supported by the registered manager and valued daily for their input within the service. One member of staff said, "I feel extremely supported within my job; they [staff] are all great and [registered manager] is always available if you need her, you can talk to her about anything". Another member of staff told us how she had been supported both practically and emotionally by the registered manager with a personal bereavement. They said, "I couldn't have asked for more support, nothing has been too much trouble". This demonstrated that the registered manager showed regard for the well-being of staff.

We found that since our last inspection, the registered manager had introduced a staff 'shout-out' scheme. The registered manager explained that this formed part of their staff appreciation system whereby staff members were encouraged to recognise, appreciate and comment on the contributions of other team members in order to enhance team morale and cohesion. Staff we spoke with told us that this made them feel valued within their work. One member of staff said, "It's nice to feel appreciated and recognised for the work you do". Those with the most 'shout-outs' were awarded with a certificate and a small gift. Team working was also enhanced by a newly introduced 'birthday club'; staff contributed to a birthday fund and celebrated each-others' birthdays in turn with a card and gift. Another team development initiative was the launch of social group chat. Staff we spoke with told us that this had enhanced social contact and communications between staff and that collectively, all of these initiatives contributed to a well-established, supportive and cohesive staffing team which they enjoyed being a part of. We found that these improvements had contributed to the reduction in staff turn-over which was recognised to have had a positive impact on the people who used the service. One relative we spoke with said, "Previously, I was concerned about the high staff turnover because [person] needs consistency, but this has vastly improved and all of the staff seem really happy now".

We found that there was an open-minded and inclusive culture within the home whereby everyone was respected for their contributions and differences. No-one we spoke with raised any concerns about bullying

or harassment within the workplace and staff we spoke with told us that everyone was treated equally and fairly. One member of staff said, "We have a diverse staffing team...no-one is ever made to feel inferior or different in anyway". The registered manager told us that the provider advocated and celebrated equality and diversity within the organisation, which included the LGBT (Lesbian, Gay, Bi-sexual and Transgender) community. They said, "There is a very inclusive approach within the organisation and whilst I wouldn't say that there was an overt LGBT community, it is recognised and spoke about which I think is good. We have internal magazines that share people's stories and this often focusses on celebrating equality and diversity; one of these recently was how staff at another service had supported someone they care for during their gender transition. We are definitely going in the right direction". It was evident that this inclusivity was extended to people who used the service and visitors, making the home a friendly and welcoming environment to all.
We found that staff were encouraged to develop within the service and were given learning and development opportunities to enhance their knowledge, skills and professional development. One member of staff told us, "If there is anything additional to the training we received that we are interested in to develop our knowledge or perhaps something new that is specific to our work, such a new health condition, we are encouraged to attend additional training". We also saw that staff were supported to grow within the service and to take on additional roles and responsibilities in order develop their skills and confidence. For example, the team leader was asked to contribute to the facilitation of the inspection including aspects of the well-led key lines of enquiries as a learning and development opportunity.

Quality monitoring systems and processes were in place to ensure that the quality and safety of the service being provided to people was regularly reviewed. This included auditing of care records, health and safety systems and environmental maintenance checks as well as feedback forums which actively sought the opinions of the people who used the service, relatives, visitors and other stakeholders. Information gathered as part of these systems and processes was analysed to identify any themes or trends in order to inform where improvements were required and action plans were developed. For example, we saw how feedback they had received by way of the complaints system had been used to inform changes within the service. For example, one relative was concerned that relevant information had not been handed over to them when they arrived to pick up their loved one who was due to spend time with them at home. We saw that this was thoroughly investigated, a letter of acknowledgement and apology was sent to the relative detailing the action that had been taken to prevent a re-occurrence in the future. This included the introduction of a new hand-over sheet which staff would write any relevant information on prior to the person leaving the home and also had space for relatives to also write their hand-over of information for when the person return to the care home. This ensured continuity of communication and care. This showed that the provider was working in accordance with the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. It also showed that lessons were learned from the review of incidents within the home.

We found that the provider's systemic quality monitoring system meant that regional operations managers also carried out regular monitory visits within home in addition to internal auditing practices and peer audits (whereby managers form the provider's other care services cross-audited each other's locations) for further oversight and internal validity checks. The registered manager said, "We are lucky to have all of the internal quality checks and oversight, so we are supported to remain 'good'". Learning from across the provider was also shared. For example, we saw the outcome of CQC inspections at the providers other services had been shared in a manager's meeting which included improvements that were required. One of these was regarding the care of people with dysphagia (swallowing difficulties). The registered manager at this location told us that they were proud of the knowledge, skills and experience of the staff at 109 Grange Road, particularly in supporting people with dysphagia. Therefore, they took the initiative to ask staff within

their service if they would support staff in other services to 'get this right'. We saw that a team leader and a support worker had devised a dysphagia auditing tool which they used when they visited other locations to sensitively assess the practice of other colleagues in order to encourage and promote best practice in this area. The registered manager told us that this had been well received, coming from a colleague to colleague level opposed to a management oversight level as it was regarded as more supportive rather than punitive and it also offered development opportunities for the staff involved. 109 Grange Road had been recognised as a pioneer in this initiative.

It was evident that the provider had a clear vision for the value of person-centred care and that they were dedicated to promoting and advocating for this within the day to day culture of the home. Everyone we spoke with told us that they felt the registered manager was as a positive role model and led by example, which had clearly had a positive impact upon the improvements noted within the service. Throughout the inspection there was a positive, calm and uplifting atmosphere within the home and we were told that this was a 'typical' day and that every day was like this. The registered manager had a strong understanding of the strengths and areas for continued development within the service and worked to a robust action plan. They recognised that a 'good' service was continuously evolving and developing with the introduction of new legislation and best practice guidelines. We saw that part of their service development plan included working towards Autism accreditation.

In order to support the development of the service further, we found that the registered manager worked closely and in partnership with external agencies. For example, they had forged effective working relationships with specialist learning disability services and health professionals such as physiotherapists, speech and language therapists and dieticians, all of whom supported the development of staffs skill and knowledge. We also found that the provider promoted engagement with the local community and they had set up 'Happy Monday' meetings within the wider organisation. These were social events that people and staff from the local area would attend and they also invited people from the local community in an attempt to 'reach-out' to those who required social support and company. We saw photographs of these events and everyone appeared to be enjoying themselves. The registered manager also told us that they would frequently hold garden parties in the summer months and would invite family, friends and neighbours. At the last garden party they partook in some charity work and raised money for the local hospice; again demonstrating their engagement with and contribution to the wider community.

We found that the provider was compliant with the requirements of their CQC registration. Providers are required by law to inform us of certain events that happen within the home (such as serious injuries, safeguarding concerns or deaths) by way of submitting a form called a statutory notification. We found that the statutory notifications we received from the provider were sufficiently detailed enabling us to have a sound understanding of events proceeding and actions taken following an event or incident within the home. Whenever we requested additional information concerning an event that they had notified us of, this had been provided to us. Further to this, the Provider Information Return (PIR) was submitted in good time and was comprehensively detailed. The information provided within the form was a true reflection of our findings and was corroborated throughout our visit.

Providers are also required by law to display their CQC rating awarded at their most recent inspection. We saw the provider had displayed the rating of our last inspection in the communal area of the home. This was seen to be conspicuous and legible as required.