Aitch Care Homes (London) Limited

Bradwell House

Inspection report

14 Brockhill Road
Hythe
Kent
CT21 4AQ

Tel: 01303239439
Website: www.achuk.com

Date of inspection visit:
20 July 2016
21 July 2016

Date of publication:
14 September 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

This inspection took place on 20 and 21July 2016 and was unannounced.

Bradwell House is registered to provide personal care and accommodation for up to 10 people. There were 9 people using the service at the time of our inspection who had a range of health and support needs. These included moderate to severe learning disabilities and very limited or nonverbal communication. Some people had additional conditions such as sensory impairment, epilepsy and autism.

Bradwell house is a large detached house situated in a quiet residential area on the outskirts of Hythe. There is a large communal lounge and adjoining dining area. Each person had their own bedroom including any necessary aids to suit individual needs, such as, special chairs and adaptations to support people with visual impairment and other needs. There was a secure enclosed garden to the rear of the premises, with a large furnished patio and raised planting areas. A sensory cabin and an arts and craft cabin are set within the grounds of the service.

Bradwell House was last inspected in November 2014. At that inspection it was rated as 'Requires improvement'. A breach of Regulation was found during that inspection and the provider sent us an action plan to tell us what they had done to make improvements. The action plan stated this breach had been addressed by June 2015.

This service had a registered manager in post. A registered manager is a person who is 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 registered manager was on holiday at the time of this inspection and the running of the service was overseen by the deputy manager. The locality manager was also present at Bradwell House to support staff and our inspection process.

Our inspection found the service offered people a homely, supportive environment and their care needs were being met.

A survey of people living in the service found they felt safe. Staff knew how to recognise signs of abuse and how to report it. They told us how they protected people from financial abuse and supported people to be safe in the community.

Assessments had been made about physical and environmental risks to people and actions had been taken to minimise these. Incidents and accidents were managed appropriately to avoid recurrences.

There were enough staff on duty to support people, and proper pre-employment checks had taken place to ensure that staff were suitable for their roles.

Medicines had been managed appropriately and equipment had been serviced on a regular basis to ensure that it remained safe for use.

Staff had received training in a wide range of topics and this had been regularly refreshed. Supervisions and appraisals had taken place to make sure staff were performing to the required standard and to identify developmental needs.

People's rights had been protected by assessments made under the Mental Capacity Act (MCA).
Staff understood about restrictions and applications had been made to deprive people of their liberty when this was deemed necessary.

Healthcare needs had been assessed and addressed. People had regular appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists to help them maintain their health and well-being.

Staff treated people with kindness and respect for their privacy and dignity. Each person had a keyworker assigned to them to give individual and focused support.

Staff knew people well and remembered the things that were important to them so that they received person-centred care.

People had been involved in their care planning and care plans recorded the ways in which they liked their support to be given. Bedrooms were personalised and people's preferences were respected. Independence was encouraged so that people were able to help themselves as much as possible.

Staff felt that there was a culture or openness and honesty in the service and said that they enjoyed working there. This created a comfortable and relaxed environment for people to live in.

Systems were in place to assess and monitor the quality and safety of the service. This was achieved by the effective use of auditing and through encouraging feedback from people, relatives and staff and continuous review.

We did not find any breaches of Regulations; however, we made some recommendations for the service to put in place.

We recommend the service review and amend their medication policy to ensure PRN practices conform with and reflect best practice in published guidance such as the Royal Pharmaceutical Society for The Handling of Medicines in Social Care or The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes.

We recommend that the medicines cabinet for medicines which require safer storage is secured in such a way as to conform to British Standard BS2881:1989 security level 1, Misuse of Drugs Act 1971. This will then provide suitable storage in the event it is needed.

We recommend the service provide furniture with handles appropriate to the environment. For example, larger handles, substantially attached to furniture. In the event of detachment the handle would not present a choking hazard or the fixing a skin tear risk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Medicines were safely administered and stored correctly.

People felt safe and staff knew how to recognise and report abuse.

Assessments had been made to minimise personal and environmental risks to people.

There were enough staff deployed to support people.

Is the service effective?

Good

The service was effective.

People's rights had been protected by proper use of the Mental Capacity Act.

Staff had received training and supervision to help them provide effective support.

People enjoyed nutritious and varied meals.

People were supported to maintain good health and had access to medical and social services as needed.

Is the service caring?

Good

The service was caring.

Staff delivered support with consideration and kindness.

People were treated with respect and their dignity was protected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Good

The service was responsive.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual and person centred.

There was a variety of stimulating activities and outings on offer.

An accessible complaints procedure was in place.

Is the service well-led?

Good

The service was well led.

Quality assurance processes were effective to ensure required actions were identified and progressed.

Statutory notifications required by CQC were submitted.

Staff felt supported and there was an open culture in the home which encouraged staff and people to share their views.

Staff had a good understanding of the values and goals of the service.

Bradwell House

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.

We undertook an unannounced inspection of this service on 20 and 21 July 2016. The inspection was undertaken by one inspector, this was because it was considered that additional inspection staff could be intrusive to people's daily routine.

We reviewed a range of records. This included four care plans and associated risk information and environmental risk information. We looked at recruitment information for five staff, their training and supervision records in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider.

We met each person, five staff and the deputy and location manager. Not everyone at the service was able to verbally share with us there experiences of life at Bradwell House. This was because of their complex needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people's responses to the daily events going on around them, their interaction with each other and with staff.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and healthcare professionals. We reviewed notifications of incidents and other documentation that the provider had sent us since our last inspection. A notification is information about important events which the home is required to tell us about by law.

Good

Is the service safe?

Our findings

People appeared comfortable with each other and staff and moved around the service and gardens as they wanted to. Where some people could have behaviours, potentially challenging to staff and others, staff were on hand to ensure they were safely supported. Feedback provided by visitors, family members and health and social care professionals about the service was positive; it reflected they felt people were safe at Bradwell House.

Our last inspection found Bradwell House was not always safe because the frequency of fire test drills required improvement and recommendations for improvement made by the Environmental Health Authority had not been completed. During this inspection we found sufficient improvement had been made.

Medicines were safely managed and administered; people got the right medicines at the right time, all staff administering medicines were trained and their competence checked. We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. Medicines were kept in a securely locked area to which only authorised staff had access. Storage temperature were monitored and regulated by refrigeration and air conditioning units.

Administration of medicines was undertaken appropriately. Staff were patient and knowledgeable, they reminded people what the medicines was and explained if pills were to be chewed or swallowed with a drink. Opened medicines were dated to ensure they were not used beyond their shelf life. Where skin creams were used, charts recorded its application and guidance ensured staff knew where, how much and when the cream should be applied. Refusal of medicine was recorded and contact made with relevant health professionals if this continued.

No medicines were given to people without their knowledge; where medicines were given with food to make them more palatable or easier to swallow, checks with the pharmacist ensured this did not alter the properties of the medicine. Staff knew how to give rescue medication for conditions such as epilepsy and about any specific or unusual requirements of how some medicines should be administered. For example, a given time before food, that one person needed to remain seated for a period time after taking their medication and any drinks that should be avoided that may react with medicines, such as some fruit juices.

Medicine administration records (MAR) included a photograph of the person, what medicines were prescribed, what they were for and details of any possible side effects. MAR charts were updated as required, hand written prescriptions or amendments to doses or their frequency were double signed by staff to show they were correct. Checks of medicines held took place daily and records showed the amounts stored were correct. Any medicines no longer needed were accounted for and returned to the pharmacy for safe disposal. Protocols were in place for 'as and when required medicines' (PRN) medicines, such as paracetamol and laxatives. These explained when they might be needed and how staff could monitor people's conditions to help them interpret people's need for them.

We identified two issues and bought them to the attention of the service. There was some inconsistency in the completion of MAR charts for PRN medicines. Although its administration, quantity and time given was always recorded each time, only some staff coded the MAR charts to show when it was offered but not required. This left significant gaps in some administration records and did not evidence that medicine had been offered. Additionally, although the service did not hold medicines subject to specific storage requirements by law; in the event that they were held, the medicines cabinet was not secured in the way it needed to be making it unsuitable for use.

We recommend the service review and amend their medication policy to ensure PRN practices conform with and reflect best practice in published guidance such as the Royal Pharmaceutical Society for The Handling of Medicines in Social Care or The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes. Additionally, we recommend that the medicines cabinet for medicines which require safer storage is secured in such a way as to conform to British Standard BS2881:1989 security level 1, Misuse of Drugs Act 1971. This will then provide suitable storage in the event it is needed.

The registered manager and key staff carried out health and safety reviews across the service and quickly identified any potential hazards. The regional location manager visited regularly to undertake service reviews which included environmental checks. We looked at all areas of the service, including people's bedrooms, bathrooms, the kitchen, laundry and communal areas; the service was clean and hygienic. Many areas were recently decorated and the service was in good repair. Capital expenditure items such as some new windows and central heating boilers had been priced and their replacement authorised. Particular attention was paid to cleanliness of floors as some people had conditions which meant a tendency to pick up small items and ingest them. Environmental checks had identified some repairs needed; these were logged as maintenance actions with plans in place for their completion. However, missing door knobs on some wardrobes and chests of drawers left the fixing screw protruding in some cases. Potentially, this presented a skin tear risk to people and a choking hazard form the detached knob and fixing. Staff told us they were aware of the potential risk and removed protruding fixings to make them safe; no incidents of cuts or related choking or ingestion had occurred.

We recommend the service provide furniture with handles appropriate to the environment. For example, larger handles, substantially attached to furniture. In the event of detachment the handle would not present a choking hazard or the fixing a skin tear risk.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. Staff knew the different risks associated with each person and how to minimise any occurrence. Risk assessments were in place to help keep people safe in the service and when outside or attending activities. They clearly set out the type and level of risk as well as measures taken to reduce risk. These enabled people to be as independent as possible. For example, they included safety in public places, transport seating plans and ensuring any protective equipment, such as safety headwear, was worn when needed. This helped to ensure people were encouraged to live their lives whilst supported safely and consistently. Risk assessments were reviewed when needed and linked to accident and incident reporting processes. Accidents and incidents were managed in a way which protected people from the likelihood of recurrences. Staff had completed detailed incident reports and the registered or deputy manager had recorded their actions in every case we sample checked. All records of accidents, incidents and untoward events were reviewed and signed of at regional level. This helped to ensure the service learned from incidents and put processes in place to reduce the risk of them happening again.

Staff knew how to recognise different forms of abuse and were confident about how to report it. There was a policy and procedure that informed them what to do. The service also held a copy of the locally agreed

safeguarding protocols. Staff knew people very well and could pick up on any changes in their moods or behaviour; which might be an indication that the person was troubled. People seemed comfortable and relaxed with each other; they readily allowed staff to support them, some people made contented noises and showed happy facial expressions. Where possible, people indicated to us they felt safe. Policies and posters encouraged staff to whistle blow if they felt something was wrong at the service; staff told us they had confidence in this system but had not needed to use it.

There were enough staff in place to meet people's needs; requests for assistance were met or anticipated promptly. Staffing was based on people's dependency levels and one to one support was provided and recorded for people who required it. People at the service ranged from independently mobile to significantly dependent. Six staff provided support for the early day shift and five support staff for the later day shift. Planning and deployment ensured a senior member of staff was on duty for each shift. Support at night was provided by two wake night staff. A member of management staff was always on site or on call. Activities and evaluation was coordinated by an additional full time member of staff. Rotas showed staffing levels were as planned in the month prior to the inspection. We observed staff had time to engage meaningfully with people and interact with them on a one to one level. Discussion with staff found they thought there were enough staff on duty. The service had a policy of recruiting to 110% of the anticipated staffing need. This meant any unplanned staff shortage, caused through illness, could be met by the over compliment of staff employed. This ensured staff knew the people they supported and were appropriately trained; support could be provided consistently and safely. A provision for agency staff was available as a last resort, but effective planning and staff management meant no agency staff had been used in the current year.

We read five staff recruitment files to make sure proper pre-employment enquiries had been made. All appropriate documentation had been completed and references, identity and Disclosure Barring Checks (DBS) checks had been recorded. DBS checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Interview notes had been kept and these showed the service had made efforts to take on the best staff for the job. There was a robust recruitment process in place; this helped to protect people using the service.

Fire alarms had been tested and documented weekly; and fire exits were clearly signposted. Staff had received fire safety training and were able to correctly describe evacuation routes. People had individual emergency evacuation plans in place describing the support they would need in case of fire. Full building evacuations had been carried out to identify any issues. Extinguishers and emergency lighting had also been regularly tested. The service had a formal strategy to ensure people received safe and continuous care in case of emergencies at sister services owned by the same provider.

Records showed the provider ensured proper checks were carried out of the electrical installation in the service; the gas safety certificate was current and portable electrical appliances checked. Appropriate testing and monitoring of water temperatures ensured people were safe from risks of scalding; variations in water temperatures were addressed immediately. Other water management checks prevented risks posed by Legionella, water borne bacteria. Arrangements were in place for the service and maintenance of the fire alarm and fire fighting equipment.

Good

Is the service effective?

Our findings

Views provided by relatives and social and health care professionals reflected that staff knew people well and understood how to communicate effectively according to individual needs. People were unguarded, reacting openly and positively when supported by staff. Some people led staff to show how they wanted to be supported or what they wanted to do; other people communicated by facial expression, behaviour, mannerism, making sounds, gesturing or with a few words. Staff understood people's communication and provided informed and wholehearted support.

Consent to care and treatment was given by people who were able to agree to it. We observed staff routinely considered consent when they were supporting people by asking, for example; "Can I help you with that?" or "Are you ok to do it yourself?" Each person had an individual communication plan. Where people were not able to communicate their wishes verbally, staff used Makaton (signs and symbols to support spoken language) and objects of reference, such as 'flash cards or key cards' with photographs or familiar images that helped them to communicate choice. These helped to ensure effective understanding between people and staff. Where needed, this included information about facial expressions, body language and gestures as well as other indicators such as people's general demeanour and what any changes may indicate. For example, how people may appear and react if they experienced pain, anxiety or were becoming frustrated. Staff were aware of people's communication needs and used them effectively. The service acted in accordance with people's wishes.

People had enough to eat and drink. Staff were aware of people's food preferences and any specific dietary requirements. For example, people who needed their food cut into small pieces to reduce risks of choking; staff had also researched and developed a menu to support a person with brittle bones, ensuring their food was rich in the vitamins and minerals recommended. Pictorial reference cards helped people choose what they wanted to eat. People had been referred to dieticians where needed, they were weighed regularly and encouraged to eat healthily. Staff understood about the risks of dehydration and ensured people requiring encouragement to drink received it and that they had drunk enough.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Individual capacity assessments had been made where there was reason to question people's ability to make certain decisions for themselves. Where it had been found they lacked capacity to do so, best interest meetings had been held. These ensured professionals, staff and where possible family members who knew people well were involved in decision making. This helped to ensure that the right decisions were made for the right reasons.

Staff had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. Restrictions could include, for example, bed rails, lap belts, restrictions about leaving the service and constant supervision inside and

outside of the service.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for each person at the service. All of the applications resulted in the granting of authorisation to impose restrictions; all granted authorisations were current, the conditions set out in them were met and the service knew when the authorisations needed to be reviewed.

People's healthcare needs had been addressed by the service. They had regular appointments with opticians, dentists and chiropodists and each person had an individual Healthcare Action Plan. This listed people's medical histories, their medication and recorded the outcomes of annual health checks with GPs. People's health needs had been assessed and the service worked with other professionals to promote people's well-being. These included epilepsy specialists, occupational and speech and language therapists as well as a psychologist retained by the provider.

Where specialised equipment was needed, for example, epilepsy bed monitors, pressure relieving mattresses and cushions and orthopaedic chairs, these had been sourced and were being used. The provider had invested in the service with adaptations to suit individual needs; most people's bedrooms and bathrooms were adapted for specific needs. For example, by the provision wet rooms, grab rails, sensory lighting and now and next boards which reminded some people what they were doing and helped to manage their expectations. One person's wet room was fitted with motion sensors to switch on water to a person's wash hand basin and shower. Other adaptations included a new access to from a person's bedroom to a grassed area of private and securely fenced garden. Day to day noises could cause the person anxiety and result in difficult behaviours, having this private space helped to reduce these occurrences.

The service used the Care Certificate as their training tool for new staff. This is an identified set of standards that social care workers should keep to in their daily working life; the expectation is staff who are new to services will achieve the competences required by the Care Certificate as part of their induction.

All Staff received regular training in areas essential to the effective running of the service such as fire safety, first aid, infection control and food hygiene. A training planner identified when training was due and when it should be refreshed. Additional training had been delivered which helped staff support people, including epilepsy, challenging behaviour and autism. All staff had received training in communicating effectively. Staff told us the training was good quality and they felt confident to do their job properly. Most care staff had completed National Vocational Qualifications (NVQ) in health and social care to level two or three. Some staff told us that they liked the fact that the NVQ training offered them the chance to progress in their knowledge and understanding; which in turn meant they could provide a better standard of care to people.

Supervision and appraisal of staff took place when planned. Supervisions are formal meetings between staff and the registered manager, but also included group supervision of some common practices as well as observational assessments. Supervisions gave staff the opportunity to raise any concerns about working practices and focussed on ideas to progress individual development of staff. Staff told us supervisions were useful for their personal development as well as ensuring they were up to date with current working practices. Supervision processes linked to staff performance and attendance and, where needed, led to disciplinary action.

Good

Is the service caring?

Our findings

There was a pleasant atmosphere in the service, some people laughed and smiled as staff supported them; a person who was visually impaired called out the first few words of a chant, staff responded with the next words of the chant. This provided visible enjoyment for the person and reassurance that staff were there. Staff made time to listen to people; they were intuitive in their support, responding to individual communication cues compassionately and always with respect.

Staff were considerate and courteous when supporting the people in their care. They were friendly and unhurried in their approach, giving people time to process information and communicate their responses. Staff were aware that different people responded to different styles of support, they were consistent in the ways they supported people. For example, short sentences helped some people understand what to do, where as other people received 'hand on hand' support to help them with tasks; staff were always mindful of people's independence and gave them the chance to do things for themselves before stepping in or prompting if needed. Care plans included guidance for staff to support people to do as many things for themselves as they could; we observed this happening during the inspection.

Where some people were visually impaired, staff spoke clearly explaining what they were doing and guiding people with things they wanted to do, for example, making a cup of tea. At meal times, staff told them what was on their plate in relation to numbers on a clock face, whether it was hot and where their drink and cutlery was. This help the person maintain as much autonomy as possible.

Staff used people's preferred names and spoke with them respectfully, being mindful of people's dignity. For example; when people needed assistance to use the toilet, staff were discreet in reminding them about this and providing support. They treated people with warmth and sensitivity.

We observed many examples of positive interactions between staff and people, with staff showing respect and kindness towards the people they were supporting. Staff also spoke respectfully and kindly about people between themselves during staff handover when discussing how people's days were going, irrespectively of any behaviours that had occurred. Staff were careful to protect people's privacy and dignity throughout the inspection. They asked people if they were happy for us to visit their bedrooms and made us aware of anyone who preferred to keep their bedroom private.

Staff were able to describe each person's support needs accurately and tell us about them as an individual. Records of people's days had been made and provided detailed information about the support and care they had received. They were particularly well developed around choice, activities and behaviours. This helped to ensure people were cared for and supported as they wanted to be and were meaningfully engaged.

Each person had a detailed pen picture profile. This included the most important things about them, the top six most important things to them and the most important areas where they required support. This provided detailed information for staff and helped to ensure staff were aware of these needs. Staff were

knowledgeable about people's life experiences and spoke with us about people's different personalities. They knew what people liked and didn't like. Staff told us they had got to know people well by spending time with them and, where possible their relatives, as well as by reading people's care records.

People were supported to maintain contact with their families and friends. The deputy manager told us about garden social events to which people's families, friends and neighbours of the service were invited to.

Care records were stored securely when not in use; all information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to support this.

Good

Is the service responsive?

Our findings

Pre-admission assessments ensured the service was able to meet people's individual needs and wishes. Care plans were developed from the pre-admission assessments as well as on-going discussion with people, their relatives health and social care professionals and the observations of staff. This helped to ensure care assessment and planning was individual, based upon people's needs and remained current and relevant. Care and support was delivered in a way that reflected people's assessed needs.

Some care plans were presented with pictorial prompts to make them easier for some people to engage with and understand. Care plans contained details of people's preferred routines, such as a step by step guide to supporting the person with their personal care. This included what they could do for themselves, however small, and what support they needed from staff. For example, elements of personal care people could do independently.

Care plans were well developed to provide staff with guidance to support individual needs, such as, identifying and providing reassurance if a person became anxious or unhappy. Behavioural support plans and risk assessments, developed with input from psychologists and behavioural support specialists, detailed the support people needed when they became distressed, challenging towards staff and others or self-injurious. They included proactive strategies, unique to each person, to help them stay well and settled; the signs and symptoms of when people became agitated; early intervention strategies of what staff could do to prevent escalation through to how to support people in crisis and recovery phases. This ensured support was planned and delivered in ways that met people's needs and, where possible, decreased the frequency of crisis and recovery phases.

Care plans contained comprehensive and specific information. This had helped to ensure specific conditions were monitored and appropriately reviewed so that the right support was provided. Specialist occupational aids were provided, for example, profiling beds and where needed epilepsy bed monitors ensured people were safe when they slept; special mattresses and cushions helped reduce the risk of pressure areas and individually designed orthopaedic chairs supported some people to sit safely and comfortably. Where people had specific conditions, for example, epilepsy, there was guidance for staff about symptoms or indicators which may precede a seizure and the support the person would need. Monitoring of seizures helped to inform medication reviews and to determine how well the epilepsy was managed. Door switches enabled some people to move around the service freely, but alerted staff to their movement.

Health action plans were in place, detailing people's health care needs. The plans contained comprehensive and specific information, including input from health and social care specialists where necessary. This had helped to ensure that health conditions were monitored and appropriately reviewed.

Daily records of support provided were comprehensive. The service placed and emphasis on ensuring staff notes captured a good description of support provided to people, any domestic tasks undertaken, individual and group activities as well as people's physical and emotional health. Frequent analysis of these

records enabled managers to evaluate the quality of support provided, how the person had engaged in their day, spot any trends and make any changes needed. This provided a continuous system of review. Separate life planners were in development to ensure pathways were mapped in order to give people the best possible opportunity of meeting their goals and aspirations. A sample planner was shown to us and we were assured work was under way to complete those remaining.

A full time activity coordinator provided a wide range of activities to suit people's varied interests and abilities. Boards of photographs in the hallways provided a visual record to remind some people what they had done. Some people had been involved in the initiative 'Clean for the Queen', a nationwide campaign to inspire Britons to spruce up their local areas in the run up to the Queen's 90th birthday in April. Other activities outside of the service included horse and cart rides, cycling, swimming, use of computers at the library, practicing reading and writing and social clubs. Some people had bus passes and two vehicles based at the service enabled staff to drive people to their various activities. An activity cabin set in the gardens of the service provided an area for arts, crafts and creativity; while a sensory cabin provided sensory lighting, mirror balls, glow in the dark stars as well as a sensory board of different textures and sounds. There was also a quiet room with music and soft furniture. Reviews of people's engagement, their enjoyment, stimulation and calming helped to ensure the activities provided benefitted the people receiving them or provided a vehicle for change if needed.

The service's complaints procedure was available in pictorial form; it was clear and included both verbal and written complaints. There were no complaints at the time of our inspection. Staff clearly explained how they would support people to make a complaint if the need arose. In a recent survey, a relative had commented, "Appreciate all hard work of the staff and feel they have managed to develop a good working relationship". Other comments were equally positive.

Good

Is the service well-led?

Our findings

Staff and people were positive about the management of the service, describing it as "supportive and fair." Staff told us they enjoyed working in the service, they were proud of the support and care the provided and they felt valued by the provider and registered manager. They described an open culture where they were encouraged to speak out with any concerns or ideas to improve the quality of the service being provided.

Auditing and checking procedures were in place within the service. The registered manager and location manager undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, medicine management, nutrition, mobility, care plan quality and building maintenance. The quality assurance framework was effective, it ensured time frames were and people appointed to make sure identified requirements were completed. Statutory notifications had been sent as needed, these are notices the service is required to send to us notifying us about certain changes, events and incidents affecting their service or the people who use it.

Established systems sought the views of people, relatives, staff and health and social care professionals and were due to be undertaken for the current year. People had completed questionnaires about their opinions of the service; sometimes with the help of their key worker. Questions covered staffing, choices, feeling safe and being listened to, and the responses were positive overall. The service had a variety of methods by which to measure the standard of care and people's experiences of it, including one to one meetings and discussions with people's families. Where people's families had made comments, suggestions for improvement or change were acted upon.

The service published its aims and objectives within its statement of purpose. This was available at the service and set out its key principles of care and what people could expect. Staff told us and records confirmed the culture within the service was supportive and enabled staff to feel able to raise issues and comment about the service or work practices; staff felt they would be supported by the registered manager and provider.

The values and commitment of the service were embedded in the expected behaviours of staff and were discussed with staff and linked to supervisions and appraisals. Staff recognised and understood how their behaviour and engagement with people affected their experiences living at the service. Staff displayed these clear values during our inspection, particularly in their commitment to care and support and the respectful ways in which it was delivered.

Observations of staff interaction with each other showed they felt comfortable with each other and there was a good supportive relationship between them. Staff felt they worked together to achieve positive outcomes for people, for example, discussing outings or the wellbeing of a person who was agitated and suggested actions.

Policy and procedure information was available within the service and, in discussion; staff knew where to access this information and told us they were kept informed of any changes made.