WALC Limited

Walc House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This announced inspection took place on 29 January 2016 and was inspected by one inspector. The inspection was announced to ensure there was a senior staff member or the registered manager at the service when we visited. The home is a residential care home and provides support and personal care for up to four adults. The home has three floors with stair and people had their own rooms. At the time of our inspection there were four people using the service. There was a garden at the back of the house for people to enjoy.

The home was last inspected on the 16 April 2014 and found not to be meeting the standards in the quality and monitoring of the service. We found that there were ineffective systems in place to capture feedback on how to improve the service.
At this inspection improvements had been made and people, their relatives and staff had been consulted through surveys and questionnaires. People had been supported to increase their involvement through meetings, questionnaires and newsletters. For example, feedback in 2015 was used to improve the service provided.

The manager who was a registered manager had been with the service since 2009. 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.

People who used the service had complex health and social care needs and used a range of methods for communicating. These included recognition of signs and pictures, use of non-verbal body language, including facial expressions, gestures, sounds and visual prompts.

The service was safe because people were at reduced risk of harm from abuse. This was because staff were aware of how to safeguard and protect people. Staff informed us of the safeguarding training they received to help prepare them for their responsibilities.

There were enough staff to safely meet people's needs. Staff worked in teams to support people with meeting their individual needs and to provide assistance with carrying out their daily care and living activities. Both teams worked four days on duty and then had four days off duty. Teams were made up of a leader, an assistant supervisor, senior support workers and support workers. Staff were safely recruited using current legislation and had the necessary employment checks before they started work. The registered manager and team leaders were responsible for addressing unsafe practice which was highlighted and addressed in staff supervision.

Staff worked on a one to one basis when helping people to identify and discuss their risks. For example, one person was at risk of becoming unwell if their temperature increased and staff observed for this more

frequently throughout the warmer season. People were cared for in a safe environment where health, safety, hygiene and maintenance checks had been completed. Staff described these checks which included an electrical appliance test, gas safety checks, fire safety audits and maintenance to repair faults and damage to the home or equipment. There were procedures for staff to follow in an emergency.

Medicines were managed safely. They were ordered, checked, administered and returned when not used safely and these were signed and recorded on people's medicine administration records (MAR). Staff were assigned the responsibility of checking stock and auditing the process.

Staff were aware of, and worked within the principles of the Mental Capacity Act 2005 (MCA). They described how this impacted on the people they supported. The registered manager told us they had requested a review of assessment for people's mental capacity from the appropriate authorities. Some people had received an assessment while others were waiting to be reviewed.

Staff spoke with people when supporting them with decisions about how their needs were met. We heard them explaining day to day activities with people and saw staff use opportunities to speak with people to gauge consent prior to assisting with care.

People were supported by staff who received regular training and development and whose performance was supported through guidance, supervision and appraisal. Staff had the qualifications, skills and or the experience to assist people when meeting their needs. Some staff were working towards leadership awards to support their roles and some had attended mental health awareness training through a national college of further education in 2015.

People were supported to maintain their health and this was provided by a variety of community health care professionals. One staff member described the health needs of two people at Walc House and gave examples of how these had been met, including appointments with opticians, dentists and speech and language therapists.

People had nutritious meals and these were provided at regular times during the day to help people develop their routines. People were prompted to choose their meals although some people had allergies or were sensitive to certain foods and drinks. In these cases alternatives or healthier options were offered and staff supported them to select a meal or drink that was safe to eat.

Staff demonstrated respect and an understanding for the people they supported. Staff knew people very well and was able to meet their needs using a sensitive yet person centred approach. Staff respected people's dignity during private time and were mindful of people's dignity when carrying out personal care. Staff gave examples of how they protected people's rights to privacy by closing doors and knocking on doors prior to invitations to enter people's personal spaces.

Staff communicated respectfully with people by using their chosen names and encouraged mutual respect between people living at Walc House. People had support from staff to help them communicate their needs. This was clearly demonstrated when staff worked closely with people to help them individually and when interacting with others.

People shared time with others but also had one to one opportunities with their named keyworker. Time was spent planning activities, discussing holidays and food menu's and reviewing care. People received care that was personalised to their interests and helped them achieve their daily activities.

People were enabled to maintain their relationships with people that were important to them. Some people had regular contact with relatives and visited their family for weekends or at holidays. People were listened to and their opinions were actively sought to identify any concerns or complaints. People were supported to raise their concerns and have them addressed. Walc House had a complaints policy and the process was made available to people using a brief picture and text flow chart.

Staff were listened to and valued for their contributions. They were involved in changes to the service and how the home was managed. There was a registered manager at Walc House who was supported by the service provider and team leaders. Staff felt motivated and supported by each other in their teams and by management, explaining that as they worked in small teams there was a greater level of transparency.

Management systems meant that regular checks took place to ensure that the service was operating safely and being monitored for quality. These checks included formal written audits of MARs, spot checks on medicine administration and health and safety checks. A recent fire safety inspection from the fire and rescue service showed that the service was meeting its fire regulations to a high standard of safety.

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. This was because staff were aware of how to safeguard and protect people. They received safeguarding training to prepare them for their responsibilities.

There were sufficient numbers of suitably skilled and experienced staff to meet people's needs. Some people required greater or more frequent support and staff were made available to accommodate their needs. Recruitment practices included pre-employment checks for staff in line with current legislation. The registered manager and team leaders were responsible for addressing unsafe practice which was highlighted and addressed in staff supervision.

Medicines were ordered, checked, administered and stored safely locked securely away from access when not in use.

People were cared for in a safe environment where health, safety, hygiene and maintenance checks had been completed. These included gas, electric and fire tests. Each person had their own personal emergency evacuation plan based on their assessed risk factors.

People's risk were assessed and reviewed. Where risks were found these were managed and documented with actions taken to reduce the risk from happening.

Is the service effective?

Good

The service was effective. Staff received training and development to carry out their roles and responsibilities safely. They had regular supervision sessions and participated in an annual appraisal.

People's consent to care was sought in line with the Mental Capacity Act (MCA) 2005. Deprivation of Liberty Safeguards had been requested and staff explained people's treatment and support before they carried out care.

People received regular health care support from healthcare professionals to meet their individual needs.

A variety of food and drinks were made available to people and meals were used as an opportunity for people to socialise. People received the support they needed to manage their meals.

Is the service caring?

Good

The service was caring. Staff demonstrated respect and understanding for the people they supported. Staff knew people very well and was able to meet their needs using a sensitive and person centred approach.

Staff respected people's dignity during private time and were mindful of people's dignity when carrying out personal care.

Staff were observed to be supportive, attentive and had insight into people's changing physical and emotional needs. People had support from staff to help them communicate their needs.

Is the service responsive?

Good

The service was responsive. People received care that was personalised to their needs. Each person had a key worker who supported them to meet their individual interests and achieve their activities.

People's interests and hobbies were met by staff who understood what was important to people living at Walc House.

People were listened to and their opinions were actively sought to identify any concerns or complaints. There was a complaints policy which staff understood and was made available to people through a range of resources.

Is the service well-led?

Good

The service was well led. People, their relatives and staff were invited to complete a survey and add their comments and feedback.

There was a shared understanding from within the management team and staff about the key responsibilities of the service and towards people living at the home.

Team meetings were used to explore challenges, convey information like the whistle blowing policy, impart information and to discuss whether changes for improvement were required.

Management systems meant that regular checks took place to ensure that the service was operating safely and being

monitored for quality. A recent fire safety inspection from the fire and rescue service showed that the service was meeting its fire regulations to a high standard of safety.

Records showed that at individual meetings the registered manager and team leaders discussed progress, values and behaviours to ensure staff understood their roles and responsibilities effectively.

Walc 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.

This inspection took place on 29 January 2016 by one inspector and was announced. The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in.

Before the inspection we looked at the previous inspection report from 2014 and notifications received from the service. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information from the provider during the inspection.

We spoke with the registered manager, four staff and three health and social care professionals. We also spoke with one person who used the service and a relative.

We reviewed two people's support plans which outlined the care, assistance and support they received. We looked at a selection of records including best interest decision assessments and outcomes, risk assessments, medicine records, activity plans, evacuation plans, health, safety, security and fire checks and a number of management records about the home. We looked at two staff files, training, development and staff support records. We also looked at recruitment processes and read several policies that supported the effective day to day management of the home.

Good

Is the service safe?

Our findings

The service was safe because people were at reduced risk of harm from abuse. This was because staff were aware of how to safeguard and protect people. Staff informed us of the safeguarding training they received to help prepare them for their responsibilities. They explained how and what they would report to their team leader or the registered manager and record any such concerns for people's welfare. Staff provided examples of types of abuse that people were at risk from. These included physical and emotional harm, neglect and financial abuse. They told us about the signs they would check for which included physical markings or unusual behaviours. One staff said, "People don't always understand the needs of our clients when we are out in the community, so it's important we know about safeguarding and discrimination". There was a whistleblowing policy to support staff and they were reminded of its purpose in meetings and at their supervisions. The policy was made available to all staff. People were reminded during group house meetings on how to keep safe and when and how to report any treatment they were concerned about. On the notice board a poster was displayed designed for people using the service. This was titled, 'Say No To Abuse'. A relative told us, "I think people are safe because the staff know them very well, so understand the risk for people". A healthcare professional described the service as "safe, and that people were well supported".

There were enough staff to safely meet people's needs. Staff worked in teams to support people with meeting their individual needs and to provide assistance with carrying out their daily care and living activities. Both teams worked four days on duty and then had four days off duty. Teams were made up of a leader, an assistant supervisor, senior support workers and support workers.

Some people required close supervision and to help keep them safe from accidents, harm or injury. Sufficient staff were available to ensure people who needed more supervision or support were accommodated. Early shifts started at 07.45am and finished at 6.45pm with three staff being available in the morning and four staff throughout the remaining day. Late shifts began at 10.45am and finished at 9.45pm. On occasions staff worked a split shift to cover busy periods of activity. Rotas were worked out in advance and when staff left the service new staff were recruited to fill the vacancies. One staff member told us, "We work in teams with different levels of experience and cover each other if there are gaps but we do recruit when staff leave the service". Night staff included one waking staff member and one sleeping staff member to cater for emergencies if they occurred. When people went on trips, visits or appointments staff were deployed to provide sufficient safe support for those who remained at the service besides those who required escort.

Staff were recruited following employment law and safe recruitment practices. These included completion of an application form, reference requests, a completed health questionnaire, checks on people's right to work and their proof of address. Staff had been checked to ensure they had not been barred from working with adults and children. The registered manager explained that existing staff's disclosure and barring status was also reviewed and these were requested and updated in August 2015. A relative told us that staff turnover was low and the service did not have to recruit frequently, explaining this was good for the people using the service.

Risks to people were regularly reviewed by keyworkers at shift handovers if accidents and incidents had happened and at team meetings. They were also reviewed routinely every four months and annually if no changes were previously required. Staff worked on a one to one basis when helping people to identify and discuss their risks. For example, one person was at risk of becoming unwell if their temperature increased and staff observed for this more frequently throughout the warmer season. One person was, on occasions, at risk of self harming behaviour when anxious in public spaces. Staff told us they chose quieter routes and avoided direct contact with members of the public if the person became distressed. At other times, excess or loud noises also contributed to episodes of self- harm. One staff member told us, "We distract and use calming activities or change the activity completely". Someone else was at risk of becoming agitated and staff reduced this by creating more structure in their daily activities which included bowling, shopping and swimming.

For someone else, diet played an important part in reducing the risk of challenging behaviour. Food and drinks that increased the risks were reduced and this was documented in the care and support plan. Where possible alternative options like de-caffeinated coffee and a different choice of fruits were considered and offered to minimise restrictions and enable personal choice. Other risks included safe supervision in the kitchen area and a sharp knife use risk assessment to protect some people from harm.

People were cared for in a safe environment where health, safety, hygiene and maintenance checks had been completed. Staff described these checks which included an electrical appliance test, gas safety checks, fire safety audits and maintenance to repair faults and damage to the home or equipment. There were procedures for staff to follow in an emergency and these plans covered fire, flood, medicine errors and several general and specific risk assessments. Each person had their own personal emergency evacuation plan based on their assessed risk factors.

The home was clean and well-kept and where hazards had been identified these had been addressed. For example, a reminder notice had been displayed where the stairwell ceiling dropped lower in height due to the design of the building. This posed a risk to taller people following a previous minor incident. The area had been highlighted and staff was reminded when working close to or when using the area. Accidents were regularly reviewed and these were documented in the relevant records. Keyworkers discussed risks and accidents during people's reviews and when discussing people's care needs with them. They were also discussed at shift handovers, team updates and during staff supervision meetings. The registered manager kept records of accidents and incidents for quality review. A relative commented "its home from home and very safe and well maintained".

Medicines were managed safely. They were ordered, checked, administered and returned when not used safely and these were signed and recorded on people's medicine administration records (MAR). Staff were assigned the responsibility of checking stock and auditing the process. In people's care records and medicine charts details were found about any known allergies and each person had their picture photograph attached to the MAR. People's medicines were regularly reviewed by medical staff and changes made when necessary. For example, one person required a change in their medicine for their condition and someone else required a change in their dose of medicine. In records of a medicine observation carried out in 2015 by the registered manager a staff member was observed explaining the type of medicine and quantity the person needed.

Medicines were stored securely and kept locked away when not being administered. Staff were aware of how to address medicine errors and described what they would do in the event of an error. This meant staff were familiar with how to administer medicines safely and what expected actions were necessary if errors occurred. The service had a medicine policy for staff to follow and they received training, supervision and

review of their skills before signed as safe to administer by the registered manager. We checked the MAR records of two people; these were found to be accurately administered, dated and signed.

Some people required skin preparations when bathing and ear and eye medicinal preparations like drops and ointments. Staff described how these were administered and stored.

Good

Is the service effective?

Our findings

People living at Walc House did not have the mental capacity to make decisions about some aspects of their care or where they lived. 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.

Staff were aware of, and worked within the principles of the MCA. They described how this impacted on the people they supported. The registered manager told us they had requested a review of assessment for people's mental capacity from the appropriate authorities. Some people had received an assessment while others were waiting to be reviewed.

Staff spoke with people when supporting them with decisions about how their needs were met. We heard them explaining day to day activities with people and saw staff use opportunities to speak with people to gauge consent prior to assisting with care.

A best interest decision was made for someone who required hospital care and treatment. These decisions were made in collaboration and discussion with hospital staff, the GP, the registered manager, the person's keyworker, and their family. This decision provided the least restrictive measures available to balance the person's right to safe care and treatment while restricting their choice which could lead to harm. This person had a Deprivation of Liberty Safeguards (DoLS) with no extra conditions attached to the safeguard. One relative described how staff kept in regular contact with families and alerted them when there were changes. A healthcare professional explained that staff had learned to involve others in a 'circle of support' when deciding on actions to take in people's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the (DoLS).

Although requests for MCA and DoLS had been submitted some people were waiting to be assessed by the appropriate staff within the authorisation department, while others had been assessed.

People were supported by staff who received regular training and development and whose performance was supported through guidance, supervision and appraisal. Staff had the qualifications, skills and or the experience to assist people in meeting their needs. Staff followed a training and development plan to assist them in carrying out their roles and responsibilities. Training included initial care related awareness and on-going annual updates including moving and handling, risk assessments, medicine management, challenging behaviour support, equality and diversity and safeguarding adults. One person told us that staff helped them with their care and support needs. A healthcare professional told us that staff formed a consistent team and were knowledgeable about the people they supported.

Some staff had previous qualifications related to care known as National Vocational Qualifications while others were working towards new qualifications and receiving support from external trainers and assessors. Some staff were working towards leadership awards to support their roles and some had attended mental health awareness training through a national college of further education in 2015. One staff member had a certificate in the principles of working with people as individuals. Staff were also expected to complete e-learning and training updates provided by videos or compact discs. A comment from a relative included, "The staff all seem very well trained; they all have regular training at Walc House".

Newly employed staff received an introduction to the service and accompanied experienced staff across several shifts as part of their induction process. They were expected to begin working towards their Care Certificate. These certificates have replaced the social care induction programmes. Two new staff had started their Care Certificates but left the service before completing.

Records showed and staff confirmed that staff were supported by team leaders and the registered manager who carried out annual appraisals to discuss care performance linked to their regular supervisions. These sessions' highlighted strengths and the learning and development needs of individual staff. Where unsafe practice was found or staff had development needs these were discussed at supervision sessions and guidance was provided and documented.

People were supported to maintain their health and this was provided by a variety of community health care professionals. One staff member described the health needs of two people at Walc House and gave examples of how these had been met, including appointments with opticians, dentists and speech and language therapists. People had regular and urgent appointments to see their GP, health promotion nurses and specialist nurses who supported people with medical conditions. One person attended hospital for tests, investigations and treatment and staff gave detailed accounts of how this had met the person's health needs. Records showed that following appointments, guidance and advice from doctors, dieticians and speech and language therapists, staff carried out care and documented this in people's care notes. Examples included dietary and medicine changes and ear related treatments. Discussions with people about their health took place before appointments and on the day of the appointment to help prepare them for their health checks. One healthcare professional told us that staff kept in regular contact with their team and made effective use of their knowledge and resources.

People had nutritious meals and these were provided at regular times during the day to help people develop their routines. One person commented that the food was good and they enjoyed their meals. People were prompted to choose their meals although some people had allergies or were sensitive to certain foods and drinks. In these cases alternatives or healthier options were offered and staff supported them to select a meal or drink that was safe to eat. People suggested a variety of meals at house meetings and then went shopping locally for the food and ingredients with the support of staff. There was plenty of food including fresh produce and meals were made a social and enjoyable event for people.

Some people's nutritional needs had been assessed by specialists and these people's nutritional intake was monitored to ensure it met their needs. Some people were at risk of eating the wrong food or were at risk of choking in certain situations and these were recorded along with the actions in their care and support plans. Staff were aware of these risks and spoke with knowledge about the actions they would be required to take. One example meant that staff had to sit beside one person to ensure they took time to chew their food and swallowed safely. In records this was recorded as guidance to staff to, 'cut food up small' and 'meat must be mashable'.

Good

Is the service caring?

Our findings

The service was caring because staff demonstrated respect and an understanding for the people they supported. Staff knew people very well and was able to meet their needs using a sensitive yet person centred approach. Staff worked in a professional way with people while showing a caring manner. For example, staff showed insight when one person became animated and excited. Staff used humour and distraction skills to help the person remain calm without spoiling their sense of enjoyment. One person became slightly distressed and staff took action to comfort and reassure them while being mindful of the needs of other people who might also have been affected. One relative told us, "You can tell that staff really care and love looking after people; they know them well and it's genuine. I'm very confident the staff meet people's needs". Another comment included, "I can visit whenever I want to". They told us that if their family member was missing them they would get a telephone call from them.

People were treated with dignity and respect. Staff respected people's dignity during private time and were mindful of people's dignity when carrying out personal care. Staff gave examples of how they protected people's rights to privacy by closing doors and knocking on doors prior to invitations to enter people's personal spaces. One staff member explained that preparing well before personal care was carried out and having everything to hand meant that people were not left unnecessarily exposed during bathing. One healthcare professional commented on the care people received and told us "It's a lovely home; the staff take real interest in people".

Staff were observed to be supportive, attentive and had insight into people's changing physical and emotional needs. For example, staff were aware when some people needed less stimulation from certain sounds, noise and people and took action accordingly to meet the person's needs. One health and social care professional praised the support workers for their care and support of one person who had attended a routine appointment telling us that staff showed understanding of the person's needs and feelings. Where people had health needs and were at risk of medical emergencies staff explained how these had to be managed quickly yet calmly to reduce any secondary risk of harm or injury. Staff spoke with compassion and concern for people and described how they understood the importance of maintaining people's physical, social and psychological well-being, providing examples of how this was achieved. One example included the level of person centred preparation involved in leading up to home visits to ensure the person's reactions and behaviours was carefully supported.

Support workers encouraged people to fulfil their hobbies and favourite activities. One person spoke about their interests and showed us games and activities they enjoyed. They told us that staff spent time with them while they enjoyed their hobbies. Staff gave detailed accounts of people's past histories, family involvement and their interests. They described how each person's sense of identity was fostered and valued. For example, one person enjoyed a greater level of social and community interaction and staff involved the person in a range of outdoor activities to accommodate this.

Staff communicated respectfully with people by using their chosen names and encouraged mutual respect between people living at Walc House. People had support from staff to help them communicate their needs.

This was clearly demonstrated when staff worked closely with people to help them individually and when interacting with others. Staff described how each person communicated by using either hand rubbing, humming and sound repetition, head movements and hand gesticulation to convey their experiences. Feedback from relatives showed that communication between staff when taking and relaying messages was effective. Changes had been made to the day to day communication about the needs of people. Information was recorded in one central area to improve handover between staff and to ensure that important information was not missed or lost.

Staff were aware of the need to protect people's personal information in a confidential manner in line with the organisation's policy. Staff explained that many people in the community knew each other well and staff were made aware of the need to show discretion and care to protect privacy and maintain confidentiality.

Staff encouraged people to be independent where this was possible. While some people were not safe to leave the home on their own, one person had a key to the main door but required support and supervision when leaving the home. Relatives were encouraged to visit the service for celebrations, reviews and special events and some people had regular visits to spend time with their families. These visits were pre-arranged or booked in advance whenever possible to ensure that people made the most of their family and social experiences.

People shared time with others but also had one to one opportunities with their named keyworker. Time was spent planning activities, discussing holidays and food menu's and reviewing care. During group meetings and at one to one periods people were invited to express their views, likes and dislikes. Staff used a variety of resources to help people have their ideas and responses acknowledged. One example included a group meeting for the four people to discuss changes at the home, what was working well and what needed attention. People were supported to make decisions and plan future trips and events. Information was provided using posters, pictorial symbols and Makaton to improve communication, awareness and understanding.

People did not have independent mental capacity advocates. When we asked about this we were told by staff that people's families were their main advocates and that most people were in regular contact with their family.

As part of one person's emotional well-being staff guided discussions about the death of their relative to help involve and support them with expressing their understanding and awareness.

Good

Is the service responsive?

Our findings

People received care that was personalised to their interests and helped them achieve their daily activities. Each person had a key worker who spent time with the registered manager, team leader and the person they supported to assess and review new and existing needs. At reviews, people and their families were invited to attend and contribute to re-planning and reviewing the individualised support that would be of most benefit. Records showed that people were encouraged to participate and promoted a sense of personal ownership where this was possible and practical. For example, one person was provided with a key to the main door although needed support from a staff member when they went out.

People's interests and hobbies were met by staff who understood what was important to people living at Walc House. For example, some people enjoyed gardening, swimming, horse-riding and visiting outdoor resorts while others preferred less active events. Staff explained how one person had enjoyed a visit to a local allotment to pick fruit, tend to vegetables and water the plants. Trips to the seaside included a visit to a beach hut and enjoying water sport activities like canoeing and paddle boat rides. One relative informed us that since their family member had lived at Walc House their personality and temperament had changed and they had experienced less challenging behaviour and self-harm. When asked why they felt this we were told "There is more stability, structure and staff continuity; people get to do what they enjoy".

There was an activity calendar which outlined a range of events and interests suitable for each person. Some of these were weather and climate dependent but people could choose other options as and when they wished. At special times of the year activities, visits and interests were linked to events like Christmas, Easter and summer. At Christmas 2015 people made decorations from salt dough to celebrate the festivities. People enjoyed day trips and planning their holidays with support from staff. People sometimes enjoyed going out with one other person and staff when shopping or visiting local areas. One person showed us their room and told us they had chosen items to personalise their space. They described activities and games they enjoyed using. A healthcare professional described people who enjoyed the range of activities offered and that people were frequently seen out in the community with staff enjoying social time together.

People were enabled to maintain their relationships with people that were important to them. This was confirmed by a relative we spoke with. Some people had regular contact with relatives and visited their family for weekends or at holidays. These were planned in advance to ensure the experience was positive and rewarding. Activities included private time and opportunities to have time alone or with their keyworker and group activities to share social experiences.

Support plans included information about people's schooling and education, their families and friends and their medical history. Details were also collected about their hobbies, sensory needs, their preferences, fears and dislikes. Terms, words, responses and reactions were recorded to help staff understand how people communicated and to meet their needs in a sensitive and caring manner. An activity room with sensory resources including soft lights and sounds was available for those who responded well to this form of stimulation and expression. People were encouraged to express their likes and dislikes using resources that would help them to express themselves and convey meaning. For example, pictures, symbols and objects

were used to assist people to make choices and reflect their interest. At the beginning of shifts people were allocated to staff members so that each person's needs could be individually met. When people had appointments or visited community health and social care services they were supported by a staff member and visit notes to ensure their care was effectively coordinated and their needs understood by others.

Staff understood people's individual's needs and this was documented in their daily records. For example, one staff member described how one person preferred baths at night to help them relax before their sleep and showers in the morning as part of their daily personal care. Another staff member explained that one person required close supervision and observation when eating to prevent them coming to harm from the risk of seizures. Someone else was at risk of harming themselves when they were exposed to new or challenging experiences and someone else had challenging behaviour on occasions sometimes as a result of contact with others. Staff explained how they used de-escalating methods and distraction to help people manage their feelings and behaviours. Some people were supported by health and social care teams and this was also documented in people's care and support plans. A healthcare professional described the support one person had received as "amazing" and explained that they had noted a positive difference in people's lives from living at Walc House.

Staff described how people's care needs changed according to their presenting symptoms. For example, on one occasion, one person's medicines were reviewed to reduce unpleasant symptoms and someone else had medicines stopped when they no longer were required. Staff told us that one person was encouraged to eat slowly and chew well to reduce the risk of choking. This was recorded in their plan following advice from healthcare professionals.

People were listened to and their opinions were actively sought to identify any concerns or complaints. People were supported to raise their concerns and have them addressed. Walc House had a complaints policy and the process was made available to people using a brief picture and text flow chart. People were encouraged to express with their keyworker any concerns during their one to one sessions or at their reviews. Minutes taken at previous house meetings recorded that staff regularly engaged with people to check whether they had any concerns they wished to convey or share. Content from these meetings documented topics the staff explored which included food, activities and minor disputes between people and their daily experiences. These were explored and staff worked with people to assist them in overcoming these challenges.

No one we met or spoke with shared any concerns or complaints with us. Families were contacted with updates and when feedback about the service was sought. This was encouraged through annual surveys, reviews and on an individual basis either by telephone or email.

Good

Is the service well-led?

Our findings

At the previous inspection on the 16 April 2014 the home was found not to be meeting the standards in the quality and monitoring of the service. We found that there were ineffective systems in place to capture feedback on how to improve the service.

At this inspection improvements had been made and people, their relatives and staff had been consulted through surveys and questionnaires. People had been supported to increase their involvement through meetings, questionnaires and newsletters. For example, feedback in 2015 was used to improve the service provided. People, their relatives and staff were invited to complete a survey and add their comments and feedback. Forms were designed to encourage involvement from people who lived at the home and these were completed with some support from staff. Positive feedback from relatives showed that they valued the care and assistance people received and felt communication had improved through the use of the newsletter and more regular contact using different mediums of communication.

Staff were listened to and valued for their contributions. They were involved in changes to the service and how the home was managed. For example, staff requested changes to how monthly salary payments were made to protect staff privacy and discussion took place on how staff roles could be adapted across shifts.

There was a registered manager at Walc House who was supported by the service provider and team leaders. The registered manager had been managing the service since 2009. At a team meeting the registered manager discussed and introduced an 'employee of the month' scheme where staff were recognised for their special skills and performance. The registered manager explained that to demonstrate fairness, staff were recognised for their special contributions and going beyond the call of duty in difficult circumstances. Others were recognised for staying late to help provide continuity of support to one person who had been unwell and for excellence within their individual roles. When staff requested a review of the supervision and appraisal process the registered manager carried out a piece of work which resulted in changes to the process and documentation used to capture progress, development and performance.

There was a shared understanding from within the management team and staff about the key responsibilities of the service. Team meetings were used to explore challenges, convey information like the whistle blowing policy, impart information and to discuss whether changes were required. These were also used to reflect on the level of care and support people received and for staff to make suggestions to improve the experiences of people living at Walc House. Records showed that at individual meetings the registered manager and team leaders discussed progress, values, staff performance and behaviours to ensure staff understood their roles and responsibilities effectively.

Staff felt motivated and supported by each other in their teams and by management, explaining that as they worked in small teams there was a greater level of transparency. Team leaders provided guidance and advice to support staff and newly recruited staff. Discussions took place within teams about the on-going and sudden changing needs of people. This was shared at shift handovers, team meetings and at people's reviews.

Staff spoke about the importance of providing support to people in a homely environment and aimed to foster a culture of effective, positive, social but respectful relationships between people whole lived at Walc House.

There was effective leadership at the service because good governance measures were used to address changes and improve the service. The registered manager explained that the provider visited the service approximately every three weeks to provide leadership support and to discuss management issues and the overall performance of the home. This was used as an opportunity for information exchange and a chance to communicate and remain up to date with how the service was running. One example of a recent discussion included details about the need to review the services vehicle use. This was to enable staff to better meet the needs of the people living at Walc House. A relative told us that the management team kept things constant while making it feel like a family home. One healthcare professional explained that the culture at the home was "open, warm and welcoming".

In December 2015 the management team met to discuss upgrading the Information Technology used at the service which has since been installed. The leadership team had discussed a variety of changes needed to improve the safety and privacy of people at the home. Other changes included fitting new windows, a new tarmac drive replacing slabs to prevent slips and trips and erecting a new fence and security lighting in July 2015. People and their relatives were informed about the changes through the monthly newsletter. The service received positive feedback from these changes by people's relatives.

Management systems meant that regular checks took place to ensure that the service was operating safely and being monitored for quality. These checks included formal written audits of MARs, spot checks on medicine administration and health and safety checks. A recent fire safety inspection from the fire and rescue service showed that the service was meeting its fire regulations to a high standard of safety.

Recent checks included daily water temperature recordings, fridge and cooked food temperature checks. An infection control and prevention audit was due to take place in February 2016. The home had an annual health and safety audit which took place in January 2016. The registered manager explained that the annual external audit arrangements were under review to better meet the needs of the service, staff and those who used it.

Changes were made when the service was reviewed or when problems were noted. For example, cleaning schedules were changed in August 2015 following confusion between staff about how, when and whose responsibility it was to clean different parts of the home. As a result the registered manager formulated a night cleaning checklist and an area task list which covered washing and bathrooms, the kitchen and lounge, the sensory space and the laundry area. The new routine meant that the sleepover staff member would carry out the cleaning and this was then checked and signed by the waking staff member on the night shifts. Day staff had their own specific cleaning routine schedule to carry out. Records were current, accurate and informative and were stored safely and securely at the service.

Services registered with the Care Quality Commission have legal obligations and responsibilities. They are required to send notification of certain events and occurrences. Registration requirements, including statutory notifications were received by the CQC within time and in line with the appropriate processes and expectations. The service had a Statement of Purpose which set out the aims and objectives of the service.