Mr T A & Mrs J Womersley

# The Goddards

## Inspection report

The Goddards Goole Road
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## Ratings

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

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|---|---|
| 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 2 February 2016 and was unannounced. At our last inspection of the service on 7 March 2014 the registered provider was compliant with all the regulations in force at that time.

The Goddards is registered to provide accommodation and care for up to 14 people. The service supports people with learning disabilities or an autistic spectrum disorder.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. 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 told us that they felt confident about their safety. We found that the care staff had a good knowledge of how to keep people safe from harm and the staff had been employed following robust recruitment and selection processes. We found that the management of medication was safely carried out.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

People that used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. They told us they were satisfied with the meals provided by the service. People had been included in planning menus and their feedback about the meals in the service had been listened to and acted on.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the service. People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

We observed good interactions between people who lived in the service and staff on the day of the inspection. We found that people received compassionate care from kind staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook

support tasks.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that the registered manager met with people on a regular basis to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

People's well-being, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible. This ensured people were respected, that they felt satisfied and were enabled to take control of their lives.

The people who used the service and the staff told us that the service was well managed. The registered manager monitored the quality of the service, supported the members of staff and ensured that there were effective communication and response systems in place for people who used the service.

## 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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

There were sufficient numbers of staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

### Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People reported the food was good and that they had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People told us that they received appropriate healthcare support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

### Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff and this was confirmed by the people who we spoke with.

The people who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

## Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences in order to provide a personalised service.

The people who used the service were able to make choices and decisions about their lives. This helped them to be in control and to be as independent as possible.

The people who used the service were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

## Is the service well-led?

Good

The service was well-led.

People were at the heart of the service and staff continually strived to improve. People who used the service said they could chat to the registered manager and relatives said the registered manager was understanding and knowledgeable.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

Staff were supported by their registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the registered manager.

# The Goddards

**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 registered 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 2 February 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. We also sought relevant information from the East Riding of Yorkshire Council (ERYC) safeguarding and commissioning teams who informed us that they had no concerns about the service.

During the inspection we spoke with the registered manager and eight members of staff. We also spoke with 11 people who used the service. We spent time in the office looking at records, which included the care records for two people who used the service, the recruitment, induction, training and supervision records for two members of staff and records relating to the management of the service. We spent time observing people going about their daily routines and have noted in this report their responses to their home environment and to the staff members who were supporting them.

Good

# Is the service safe?

## Our findings

People who used the service said they felt safe and that they could discuss any worries or concerns they may have with the registered manager or the staff. One person told us, "It is lovely here, the staff are great and we all get along really well."

The registered provider had policies and procedures in place to guide staff in safeguarding people. The registered manager had completed the local council's safeguarding training including the use of their risk assessment tool, and checks of two staff files indicated that the staff had completed safeguarding training during their induction and again as refresher training. The registered manager and the members of staff on duty were able to clearly describe how they would escalate concerns, both internally through their organisation or externally should they identify possible abuse. Discussion with the local council's safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service.

We had been notified of 11 safeguarding incidents in the last 12 months. These had been reported to the local council's safeguarding team and no further investigation had been needed in the majority of the incidents, which were around altercations between people living in the service. However, we saw that on three occasions the registered manager had asked for input from relevant health care professionals and amended risk assessments and care plans to ensure people remained safe and well. This demonstrated to us that the service took safeguarding incidents seriously and ensured they would be fully acted upon to keep people safe.

We saw there were behaviour management plans and risk assessments in some of the care files we looked at. These detailed the types of behaviour exhibited by individuals and what impact this had on them and others around them. Staff had identified trigger points and patterns of behaviours and the care plans gave staff clear instruction on how to diffuse situations and keep people safe from harm. Where necessary, staff received advice and guidance from health care professionals such as the Humber Mental Health team and the Community Team for Learning Disabilities (CTLD) nurse. People were also able to talk to these professionals and discuss their anxieties, behaviours and how these affected them.

The registered manager demonstrated a high level of understanding of the need to make sure people were safe. For example, they had told people about the fitting of new gates to the entrance to the service in 2015 and people told us they had the opportunity to practice at opening and shutting these so they knew how to work them if they wished to go out. Road safety was discussed at the monthly house meetings and people's knowledge and skill around this was clearly documented in their care files.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. They completed an analysis of these to identify any trends or problems within the service. We saw that the last analysis showed two people were admitted to the local hospital's accident and emergency department in 2015 for minor issues and there were four slips/trips in 2015. Appropriate care and treatment had been given to people following these incidents.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety, portable electrical items, electrical wiring and the gas system. We saw that there was a risk assessment in place for Legionella, which is a water borne virus and this had been reviewed in February 2015.

The service did not have any passenger lifts to the upper floor and there were no hoists or slings used, including bath hoists. Appropriate moving and handling equipment had been organised by the registered provider when needed in the past, but was not required at the time of our inspection. There were a limited number of bedrooms on the ground floor for people who needed some support with their mobility. However, the majority of the people were fully mobile.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for hot and cold water outlets, fire doors and call points, emergency lights and window opening restrictors. These environmental checks helped to ensure the safety of people who used the service.

We looked at the registered provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. It was reviewed in October 2015.

Staff told us, "Staff are aware of emergency procedures in terms of incidents to people, for example if someone collapses, or in terms of the environment, such as in the event of a fire. We do fire drills and training." We found that the fire risk assessment was reviewed in June 2015 and a fire drill was carried out in October 2015, December 2015 and January 2016. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were in each person's care file and were up to date.

We saw rotas indicated which staff were on duty and in what capacity. The rotas showed us there were adequate staff on duty to support people safely and enable them to take part in activities. The staff team consisted of care staff, a chef, domestic staff, maintenance staff and office staff. The registered manager told us that the care staff also carried out some kitchen and laundry duties. We observed that the service was busy, but organised. Staff worked in and around the communal areas throughout the day and we found that requests for assistance were quickly responded to.

Staff told us, "The levels of staff are good. We have enough on duty to enable us to offer people the support they need and carry out day to day tasks in the home." We found that there were 11 people in residence and there were usually three care staff on duty from 8am to 10pm. Two staff then came on duty and both were awake throughout the night. The registered manager told us that staffing in the service was flexible to accommodate health appointments and social activities in an evening. As the registered manager was also the registered provider they could adjust the staffing levels as needed. The registered manager was on duty

Monday to Friday within the service and offered additional support as needed.

We looked at the recruitment files of two members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files. The registered manager carried out a monthly audit of medicines; the last one was dated 25 January 2016 and indicated that there were no concerns about medicines at that time. The community pharmacist had visited in July 2015 and their report also found no issues of concern.

We observed staff giving out medicines at the lunch time meal. Staff communicated effectively with people, even those who could not say if they were in pain or in need of any medication. Staff told us, "We know the people who use the service. We look at their posture, their facial expressions and the majority of people can use gestures to let us know how they are feeling." Two people said the staff gave them their medicines and that they were very happy with this arrangement. The two care files we looked at included care plans on medicines and communication. The care plans took people's abilities and needs into account and were written in a person centred way. We saw evidence in the care files that people had their medicines reviewed by their GP on a regular basis. This meant people's health and wellbeing was reviewed and they received their medicines appropriately.

Good

# Is the service effective?

## Our findings

People told us they got on well with the staff and were able to talk about their care and support whenever they needed to. One person said, "[Name] is my keyworker, they help me clean my room and go with me to the Doctor's and the hospital. I can do a lot of things myself, but they are around if I need any help."

People who we spoke with told us that staff only carried out tasks or provided assistance with personal care when they had obtained consent or 'implied' consent, and that they were encouraged by staff to make decisions about their care. We saw that the care plans were signed by people wherever possible to indicate these had been discussed and agreed with them. One person told us, "The staff are great and they are here to help us. I like going out with them and you can do what you want to do, within reason. They talk to me about things that are bothering me and we sort everything out."

We looked at induction and training records for two members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the service. The registered manager showed us the induction paperwork completed for staff in their first three months of employment. We found that the registered provider used the 'Care Certificate' induction that was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource. We saw documentation that indicated new staff shadowed more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork. All new staff were introduced to the people who used the service at the time of their job interview and during their induction, so there was already a degree of knowledge before new staff worked as part of the staff team.

We saw that the staff team had access to a range of training deemed by the registered provider as both essential and service specific. Evidence in the staff files showed us that staff had completed training such as fire safety, medicine management, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. The staff training plans also showed that they had completed courses on learning disabilities and dementia care, epilepsy awareness and management of diabetes.

Checks of the staff files showed that they received regular supervision from the registered manager and had a yearly appraisal of their work performance. Records seen indicated that supervision meetings were held every two to three months and we found that the supervision sessions were recorded in detail and included action plans. Staff told us that they found the supervision sessions beneficial as they could talk about their concerns and were given feedback on their working practice. This was confirmed by the records we looked at. This meant that staff practice was monitored and reviewed to make sure people who used the service received a good standard of care.

Information in the care files indicated people received input from health care professionals such as their GP, psychologist, dentist, optician and chiropodist. People told us how they could access outside professional help if they needed to. One person said, "I go to see my doctor when I don't feel well. The staff go with me to help me." Each person had a health action plan in their care file, which had been put together by the local

GP. This document was written using a clear print format and pictorial information, which people found easier to understand. The registered manager told us that the GP allotted people an hour time slot when they went for an appointment. That gave the GP time to talk with people and allowed people to take the time to listen and ask questions. We saw that people had their medicines reviewed regularly and blood tests were carried out where necessary.

Evidence in the care files showed that people had good access to specialist health care professionals such as the Speech and Language Therapist (SALT) and the community team for learning disabilities (CTLD). People also saw other professionals such as the dentist, optician, and dietician as needed. Input from psychiatrists and psychologists was sought for some people and all visits and outcomes were recorded in the care files. We saw that input from these specialists was used to develop the person's care plans and any changes to care were updated immediately. This meant people's health and wellbeing was monitored so they remained well and received appropriate care and support.

Each person had a health 'passport', which was taken with them to hospital or medical appointments; they gave clear information to other health care professionals about the abilities and needs of the person where they had difficulty communicating with others. For example, one person who had no verbal communication was afraid of hospitals and their passport clearly recorded this and told others how best to put them at ease.

Some people struggled to verbally communicate with the staff and others in the home. However, the staff were able to tell us how the use of facial expressions, body language, laughs/smiles and shouting out was each person's way of communicating. We observed staff to be kind, patient and intuitive with people who could not directly say what they wanted or needed.

People were weighed on a regular basis according to their needs; this usually meant a weekly or monthly check by the staff which was then recorded in their care file. The care staff monitored their weight gain or losses and liaised with the GP, dietician and SALT as needed. For example, one person had a 'mealtime prescription' in their file, which had been completed by SALT. This gave care staff information about the most appropriate way to ensure the person enjoyed their meals, within a safe environment for them. It described the best position to sit them in, the equipment they required to eat and drink safely and their specialised diet and fluids. It also noted what assistance the person needed and what they could do independently.

The majority of the staff had completed food hygiene training in the last two years. This was confirmed by the certificates we saw in the staff files. We saw that the catering areas were clean and tidy with staff having completed kitchen cleaning sheets and temperature checks of fridges and freezers. We saw evidence that the service had a 4 star (good) rating from the local council's environmental health team. This meant people's nutrition and hydration needs were met by staff who followed good hygiene practices and ensured the kitchens were fit for purpose.

We saw that menus were planned on a four week rotation system and the minutes of monthly service user meetings evidenced that menu plans had been discussed. We saw that care plans detailed each person's likes and dislikes with regard to eating and drinking. The care staff were responsible for producing breakfast and lunch time meals and the chef came on duty in an afternoon to prepare the main meal of the day which was served in an evening. The chef told us they devised the menus using their catering knowledge and qualifications to ensure these were nutritious and met people's needs. They gathered feedback from people on an individual basis and at meetings. From this information they knew some people liked traditional meals, but the majority enjoyed more spicy foods. For example, the meal that evening was a chicken curry.

However, one person was having plain chicken and mashed potatoes as that is what they preferred.

Observation of the midday meal showed that people were having a selection of sandwiches, crisps and yoghurts. One person was on a soft diet and they had an appropriate meal prepared for them. The meal time was organised and people were quickly provided with a drink and their choice of food. We saw that the meal time experience offered people a social and stimulating activity that promoted their independence. People who spoke with us said they really liked the food on offer and that if they did not like something then there was always a choice available. One person told us they liked helping prepare their lunch as it helped them practice for when they lived on their own.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff told us they had received training on MCA, DoLS and equality and diversity which had given them more confidence in the way they approached people who used the service. This was evidenced in their training files. They were able to tell us about how they used this knowledge in their daily practice such as supporting people to make decisions. We saw in care records that staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions.

People told us there were few if any restrictions on their day to day life. One person told us, "We can go out on our own or with the staff depending on what we want to do. I like to walk in the gardens and we get to ride in the 'bus' and go to places we want to visit." We saw that some people were able to walk into the local village on their own to do personal shopping. Everyone had received training on road safety and use of public transport. Details of their skills and abilities to keep themselves safe were recorded in their care files.

The registered provider had a policy and procedure for physical restraint. This had been updated in October 2015 and said that minimal restraint would be used by care staff to avoid personal harm to people using the service. When we asked the registered manager what this policy meant in practice, we were told that restraint was never used and that the policy would be amended straight away to reflect this and ensure staff had the most up to date guidance on the practices used within the service.

Our observation of the service showed that some repairs were needed to furniture and fixings in two bedrooms we looked at. One bedroom had a fire door that was not closing properly. This was reported to the registered manager and was fixed by the maintenance person the same day. Another bedroom had been damaged by the person living there and we saw that the wardrobe door was missing and some of their chest of drawer fronts. The sink unit in this bedroom was also 'wobbly'. Discussion with the registered manager and the maintenance person indicated that the furnishings would be replaced within the next month and

the sink would be secured within the week.

Good

# Is the service caring?

## Our findings

People were supported in everyday activities of daily living. We saw staff offer gentle physical and verbal prompts to assist people to make drinks and simple snacks. We also observed people going out into the community; some were able to do this on their own and others were supported by staff. Individuals told us "I am going out for a coffee", "I like to go out shopping" and one person said, "I enjoy getting out and about on my own." Staff told us, "We try to encourage people to be as independent as possible. People enjoy baking, doing household tasks and going shopping for personal items as it helps them gain important life skills."

Discussion with people, the registered manager and members of staff indicated that the care being provided was person centred and focused on providing each person with practical support and motivational prompts to help them maintain their independence. We were told that regular discussions about care and support were held with people who used the service. People had a key worker and they wrote notes in the care files to show where people had been, activities they had attended and what issues had been discussed.

Observations of the interactions between people and staff showed there was a good level of trust and friendship between them all. People were at ease in the service and the conversations being held between people were very much the same as you would expect within a large family. People spoke about what they were doing, what they were having for lunch and who they had seen that day. A number of people had the same friends and interests so were able to talk about familiar things and we noted that everyone was included in the conversations.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care plans included information about a person's previous lifestyle, including their hobbies and interests and the people who were important to them. This showed that people and their relatives had been involved in assessments and plans of care. Some people had signed their care plans to show they agreed to the contents. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the entrance hall of the service. Discussion with people who used the service indicated that they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Although we did not speak with any relatives during our inspection we saw a number of comments had been made in the last satisfaction questionnaire completed in 2015. Relatives had written, "Always something going on and everyone seems happy", "Very caring staff and a happy place for people to live" and

"Staff go the extra mile."

We observed that staff displayed kindness and empathy towards people who lived in the service. Staff spoke to people using their first names and people were not excluded from conversations. We saw that staff took time to explain what was happening to people when they carried out care tasks and daily routines within the service. The majority of the staff spoke with people in a tone and manner demonstrating kindness and respect and people responded positively towards the staff. However, we noted that the way one staff member spoke to people was 'paternalistic' even though we found their intentions were good. For example, they referred to one person as being "A good girl" on two occasions. The registered manager told us this had been picked up by themselves and other members of staff and the issue was being dealt with.

People who lived in the service told us that staff were friendly and they felt staff really cared about them. One person told us, "I like living here and the staff are alright. They are kind and they listen. I can make decisions about what to wear, when to get up and when to go to bed." Another person told us, "It is alright here. I can go outside. It's nice people here. I am happy with the care here."

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required.

Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift and reading the care plans. People who used the service told us that staff respected their wishes and would listen to them when they wanted to make changes to aspects of their care.

Good

# Is the service responsive?

## Our findings

The staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People who used the service told us there were few or no restrictions on their daily life, although risk assessments had been completed and behaviour management plans were in place to make sure people stayed safe and well. Evidence in the care files showed us that people's views were sought and listened to, and that families were also involved in reviews of people's care.

Care plans were person centred and written in a clear print and pictorial format that people could easily understand. However, because the staff had such a good knowledge of each person's needs, wishes and choices some details in the care plans lacked clarity, as staff relied on what they knew to fill in any gaps. For example, one care plan said the person needed advice about how they looked and what clothes to wear, but did not say what this person's preferences were. Discussion with the registered manager and staff showed that they knew exactly how this person liked to dress and what styles they preferred. The person confirmed with us that staff helped them on a daily basis and that they were able to make their own choices and decisions with minimal encouragement and support. The registered manager told us that they were working with staff to make the care plans more detailed to promote continuity of care should new staff be delivering their care and support.

Although the majority of the care files were well written we were concerned that the terminology used in one person's care file was not appropriate. For example, one care plan used the word 'Misbehaving' in relation to their behaviours. This wording was paternalistic and old fashioned, making the person appear to be childlike, which was not the case. Another care plan detailed the risk of this person forming a 'boyfriend' relationship with another person using the service. However, it did not say why this was to be discouraged. We also saw that the goals section had one goal identified as, "To be more socially acceptable (to stop swearing)" and our query to the manager was "Is this [Name's] goal or is it the goal of the staff on the person's behalf?" The registered manager was able to answer our queries around this person's care and support and gave assurances that the care file would be reviewed and rewritten immediately.

Regular contact with family and friends was encouraged by the staff. However, where people had expressed specific wishes regarding contact or no contact this was clearly recorded in their care files and respected by the staff. Each care file contained a document called 'All about me' and this was detailed about what was important to each person. For example, for one person this was family, arts and crafts, shopping and exercise. People had signed their care plans where possible to say they had read and discussed them with staff and these were reviewed by staff informally every six months and on a formal basis every 12 months.

People were enabled to attend local colleges, day care centres and social clubs in the community. The

registered provider had a minibus to take people to and from their various social, educational and health related appointments. On the day of our inspection four of the 11 people using the service went out shopping to Selby. On their return they showed us what they had bought and told us how they had spent their time. One person had taken a number of photographs of the local abbey and their friends, which demonstrated that everyone had enjoyed their trip out.

People told us about the variety of hobbies and interests that they pursued whilst living in the home. One person showed us the woodcraft objects they made with support from their parent on a weekend, another person went to the gym with their parent. Other people enjoyed making jewellery, swimming and bowling. We were told by one person that they had been painting today and saw that nine people were going to a social club the evening of our inspection.

The registered provider supported people to move on from their service when they showed the skills and abilities to do so independently. We spoke with one person whose aim was to live in supported living accommodation in the local community. We saw that this had been discussed with them and they had a number of 'easy read' leaflets in their care file about different opportunities they might wish to explore.

We saw that there was a complaints policy and procedure in place for the service and this had been reviewed in October 2015. There was a leaflet on display telling people about keeping independent, how to make a compliant and how to access an advocate should they require one. This was available in an easy read format which was suitable for people who used the service. Checks of the complaints record held by the registered manager showed that there had been no formal complaints made in the last year. The registered manager told us that by dealing with the smaller niggles and grumbles promptly they found things did not escalate into formal complaints. People who used the service said they could complain to staff if they had any issues and when asked they told us they were "Alright."

We saw evidence of people's satisfaction with the service in the form of written cards and letters sent in by their families. One recent letter spoke about "The good staff care and loving attention given to their relative at the end of their life." The relatives' comments in the 2015 satisfaction questionnaires also said, "Any concerns are rapidly and fully investigated" and "Any problems are communicated promptly and fully." This indicated to us that there was a high level of satisfaction with the way the service dealt with issues and communicated with families and people who used the service.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post who told us that they monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People we spoke with knew the registered manager's name and said they had the opportunity to speak with them each day. We observed the registered manager as they carried out duties around the service. People seemed at ease with them and one person told us, "[The manager] is always around if you need them. You can tell them anything and they understand what you mean."

Our observation of the service was that it was well run and that the people were treated with respect and in a professional manner. We asked the staff on duty about the culture of the service and they told us, "It focuses on person centred care and is based on people being treated as individuals. We work towards improving the quality of their lives." In the 2015 satisfaction questionnaires health care professionals had said, "I have always had the utmost respect for [manager], they are an inspirational manager who is extremely competent, professional and kind" and "[Manager] is always professional, knowledgeable and caring."

The registered manager was fully involved in the everyday care of people living in the service and staff said that they felt well supported and were not asked to do tasks they were not confident about completing. The staff training plan showed that all care staff completed foundation training in learning disabilities and then went on to undertake vocational training courses such as diplomas in health and social care to further develop their knowledge. This demonstrated that people were looked after by well trained and knowledgeable staff, who were confident and capable of meeting their needs.

Feedback from the people who used the service and the staff team was obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. We were able to look at a selection of documents that confirmed this took place; a meeting was last held with the staff team in December 2015 where they spoke about documentation and person centred care. One relative had commented in the 2015 questionnaires that, "The Goddards has an excellent reputation in the area, this has been earned by hard work and outstanding care of all residents and respite users." Another relative had written, "[Name] is still happy living at The Goddards. All their needs are taken care of, one big happy family. All staff are very friendly and welcoming."

People attended house meetings each month, the last minutes we saw were for November and December 2015. The minutes were available in an easy read format of clear print and pictorial sections. These identified that people were able to discuss the menus, how to make a complaint, talk about what activities they would like to do and achievements that each had made.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The registered manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in

January 2016 and covered areas such as reportable incidents, recruitment, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.