PossAbilities C.I.C

Leighton 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?	Outstanding

Summary of findings

Overall summary

Leighton House offers short-term support and accommodation for up to five people over the age of 18 who have a learning disability or Autism. They provide respite to parents and carers of people who are cared for in their own home. Admissions to the home are usually planned but the service can also be provided if an emergency arises. Leighton House is adapted to meet the needs of profoundly disabled individuals. There are a number of communal areas including two lounges, an accessible kitchen and a garden. There is parking and access to a local bus route nearby. There were three people accommodated at the home on the days of the inspection.

At the last inspection of October 2015 the service were in breach of Regulation 12 for unsafe administration of medicines. The service sent us an action plan on how they would improve. We saw that at this inspection the improvements had been made.

Staff were consistently kind, caring and supportive and although most often they only supported people for a short period of time had developed positive relationships with people who used the service and their families.

The views of people who used the service were sought regularly using people's own individual communication methods.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff also supported family members, for instance the service could take people if there was an emergency to ensure their care was maintained. Staff tried as much as possible to ensure that when people came into the service they followed their routines and activities they normally did at home.

The registered manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and worked to ensure people's rights were respected.

Staff were supported to undertake their roles and had incentives to perform better. Staff also received induction, training and supervision relevant to their roles. This ensured they had sufficient knowledge to meet people's needs.

Managers at the home and head office audited systems to help maintain and improve performance.

There were safe systems in place for the storage and disposal of medicines. Staff received training in how to administer medicines and had their competency in this area assessed.

People received individual care packages which took account of their needs which were mainly a learning disability or Autism. Staff were trained in the care of people with these conditions and how to safely de-

escalate any behaviours that challenge. There was also the provision of equipment such as track hoists for people with mobility issues.

People were able to raise their concerns which were acted upon by the service.

People were able to attend activities of their choice which were suitable to their age, gender, culture, ability and religion.

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.

The administration of medicines was safe.

Risk assessments were in place for both people who used the service and for the environment.

Safeguarding policies, procedures and staff training helped protect people from abuse.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People who used the service were supported to take a nutritious diet.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily support the people who used the service.

Is the service caring?

Good

The service was caring.

Records were maintained securely and staff were trained in confidentiality topics.

People who used the service told us staff were trustworthy, reliable and friendly.

We observed there were good interactions between staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns.

If it was part of their care package people were able to join in activities suitable to their age, gender, culture, religious beliefs and ethnicity.

Plans of care were developed with people who used the service or where necessary family members, were individualised and kept up to date.

Is the service well-led?

Outstanding ☆

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care agency.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they felt supported and managers were approachable.

Leighton 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 was an announced inspection and was conducted by one adult social care inspector on the 26 and 27 February 2018.

We requested and received a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help with planning the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We asked the local authority and Healthwatch Rochdale if they had any concerns about the service. No concerns were raised.

We spoke with two people who used the service, two relatives, the registered manager and five care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care and medicines administration records for three people who used the service. We also looked at the recruitment, training and supervision records for three members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

A person we spoke with said, "I feel safe here." Relatives we spoke with told us, "My relative feels very safe at Leighton House." and "They are safe when they are there."

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. We saw that management audited any safeguarding concerns to analyse ways to help reduce further incidents. Staff we spoke with said, "I am aware of the safeguarding and whistle blowing policies. I would report poor practice or safeguarding concerns. I would go to management if I needed to" and "I am aware of the whistle blowing policy and would use it." There was one safeguarding incident recorded at the service. The allegations were being investigated in a timely and fair manner but initial findings looked like they were unsubstantiated.

There were safe recruitment and selection processes in place. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. Two written references were obtained and any gaps in employment checked to ensure staff were safe to work with vulnerable adults.

Risk assessments we saw in the plans of care helped ensure care was safe but allowed people to remain as independent as possible. We saw that risk assessments were undertaken and reviewed for personal care needs, the environment and to be safe in the community. A person's age, gender, disability, religion or sexual orientation was assessed and any risk assessments would take account of any special needs. We saw examples of special diets and where a person's religious needs were being met.

People were supported to take risks, which was balanced with their safety and health care needs. Staff identified when certain behaviours from people could impact on their safety and others within the home. Staff considered what triggers may affect behaviours so these could be avoided, for example one person could be resistive to personal care and another had no concept of the dangers of traffic.

There were sufficient numbers of staff to look after the people accommodated at the home. There was a system to ensure enough staff were on duty for pre-booked respite care and staff can be called on when needed from a sister home or the main part of the service, the Cherwell Centre. A staff member said, "There are normally enough staff to meet people's needs."

There were safe systems to administer medicines. At the last inspection the service did not check the temperatures of where medicines were stored. It is important to check these temperatures to ensure they remain effective. At this inspection records were maintained and we saw temperatures were within the manufacturers guidelines.

The medicines administration records (MAR) were also not accurate as some drugs held in the cabinet did

not tally with the numbers in the recording records. We checked the records and found them to be accurate at this inspection.

Staff were trained in medicines administration and regularly had their competency checked. The service had access to a copy of the best practice guidelines developed by the National Institute of Clinical Excellence (NICE) for the safe administration of medicines. We looked at the storage and recording systems and found them to be safe. Medicines were checked in when people came for respite care and checked out again when they left. There was provision to obtain medicines in an emergency if a person ran out of any medicines, which were usually provided by families. The systems in place showed people were kept safe from the risks associated with the management of medicines.

The service was clean and tidy on the days of the inspection. There were systems to prevent and control infection. The service used best practice guidelines developed by the National Institute of Clinical Excellence (NICE) to prevent the spread of infection and staff had access to personal protective equipment when needed. There was a cleaning rota which was recorded to ensure work was undertaken. Managers regularly audited the infection control systems to keep people who used the service and staff safe. We saw the audits which were robust.

The provider had a policy in place for investigating concerns, accidents and incidents. We saw how an investigation detailed the steps involved and included looking at why the incident had occurred and identifying any action that could be taken to keep people safe. This meant the registered manager and staff had clear guidance on how to investigate accidents and incidents and learn and make improvements. There was always a debrief after any behaviours that challenge occurred. This was to support staff and try to find out if there were any triggers that could be avoided. Actions taken from concerns included a person was issued with a profiling bed to help keep them safe and one-to-one support arranged for another person due to their behavioural issues.

We saw from looking at records that the service maintained equipment. This included an electrical installation certificate, gas appliance servicing and a portable appliance test (PAT) to ensure electrical equipment was safe.

Staff practiced and followed the procedures for emergencies such as a fire. Each person had a personal emergency evacuation plan (PEEP). This was a document which showed what needs a person had for evacuation and could be given to the fire service to help get people out of the building in an emergency.

The service had a business continuity plan which set out how the service would function for any emergency such as a fire, loss of utilities or inclement weather. The plan highlighted the numbers for key staff and other organisations to help get services up and running as soon as possible.

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service used the NICE decision making and mental capacity guidelines for the MCA, DoLS and best interest meetings which is considered to be good practice.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff had received training about the MCA and understood how to support people in line with the principles of the Act. 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. The registered manager said, "We have completed best interest meetings and Deprivation of Liberty Safeguard (DoLS) applications. Because it's the parents that need the respite if people stay longer than 72 hours and do not have capacity we will put in a standard application." There were seven people who had received a DoLS and six people were awaiting the outcome of an application. The DoLS were issued for people staying in a care home who may not have the mental capacity to understand why.

The applications were made through the correct channels and people had access to an Independent Mental Capacity Advisor (IMCA) who is a person who acts independently to protect a person's rights and helps ensure and restrictions on their liberty is the least restrictive.

People were supported to maintain their nutritional needs. Staff received training in good nutrition and told us they would advise people to take a healthy diet. The service could and did cater for special diets for cultural or health needs. On assessment people helped complete a food and fluid pen picture. Records we saw showed one person needed gluten free food, had input from a speech and language therapist and one person also required specially prepared food for their cultural needs. . Staff used people's known communication methods to determine what they liked to eat including the use of pictures, easy read information or use of a notepad and pen.

People were encouraged to help practice their cooking and baking skills if they were able in the kitchen. One person in the home made his own drinks and was happy to make one for staff if they wished. This person also wanted a fish and chip lunch and was taken out to get one. There were sufficient stocks of food and fluids. One person was in danger of becoming dehydrated and we saw that there was a regime to ensure this did not happen.

Staff were trained in safe food hygiene. One staff member said, "If somebody had poor nutritional intake I would give advice but we cannot force anybody to eat what we think is good for them." We saw from quality assurance feedback forms that people said they liked the food at Leighton House.

We saw that the service provided a comprehensive induction, including completing the care certificate if

they were new to the care industry. The service had also developed a new training pack specifically for staff working in respite care. This included the names and photographs of senior and support staff, an introduction to the service, settling into the service, the contract and job description, payroll dates, health and safety, skills for care codes of conduct for health and social care workers and the health and safety induction training pack which covered fire safety, first aid, welfare facilities and health and safety topics. New staff were mentored by new staff until they felt confident and competent to work with vulnerable adults.

Staff told us, "I think we do enough training to give us the skills to do the job. I did training called active support which showed us different ways to support people to become independent. More emphasis on life skills and it is good" and "We get plenty of training. I feel competent and confident in my role." Training was ongoing for all staff and included mandatory training such as health and safety, first aid, food safety, fire safety, medicines administration, infection control, the MCA and DoLS and moving and handling. Staff were encouraged to complete a recognised course in health and social care. Staff also had access to training for Autism, learning disability, behaviours that challenge and end of life care. This ensured staff had the skills to meet people's needs.

Staff also said, "I get supervision regularly and any problems I can go to my manager" and "We have formal supervision. We can discuss our careers." We saw that supervision was held regularly and appraisal yearly. Staff also had access to managers for support. Staff were able to discuss their careers and this support enabled managers to monitor their performance.

We saw people had access to professionals including GP's, specialist nurses, dieticians, hospital consultants, occupational therapists and dentists. We saw that staff would escort people to appointments, which was recorded in the plans of care if the arrangements had been made prior to admission. This helped meet people's health care needs.

The environment was suitable for people who used the service and had bedrooms on the ground floor which were adapted for people who had mobility problems. People who used the service usually chose the room they wanted to stay in and in the past had helped choose the décor. Four of the bedrooms had en-suite facilities and there was a bathroom available for the other person if the home was full.

We saw there was equipment for people who had a physical disability (A track hoist). This is a hoist which moves people from one room to another mechanically. There were two lounges, a kitchen and dining area. The garden was accessible and had a seating area for use in good weather. There was also wheelchair access if people required it.

We saw that staff asked for consent before assisting someone and encouraged people to do the things they wanted to do. Families were consulted about people's care and best interest meetings were held for supporting people who may not understand their care. Best meetings were held with the person if possible, family members, staff from the service and professionals from other organisations. This helped ensure people got the care they would choose themselves if they were able to tell staff because people who knew them best supplied the information.

Each person was assessed prior to admission. This could be a brief phone call if the person used the service regularly or an extensive visit. For new people we saw examples of the assessment process. A case study was produced which looked at their background history, where other services and professionals were involved with the person's health care, social needs and family relationships. People were encouraged to start with short visits, take a meal, perhaps go for an activity or stay for one night. The person was observed to see how

well they were able to settle in. There was a staff member dedicated to assessing prospective service users to ensure there was a consistent approach.

Plans of care and other documentation showed how staff communicated with people in various ways to ensure they were aware of what people wanted. A lot of the documentation was in an easy read format. Staff also used pictures to help people communicate their needs, electronic aids like a communication pad or pen and paper. We saw that staff had a good knowledge of how people communicated which helped ensure they could meet their expectations. The service trained some staff to be champions. Staff are taught specialist knowledge about a specific aspect of care and support. Two staff were communication champions. They provided expertise on sensory stories, talking mats, dignity and creating tools to assist people. The tools would help explain to a person who used the service, in easy terms, topics such as going to the dentist or moving house to help alleviate any distress. The champions passed on their knowledge to staff who needed assistance.

Good

Is the service caring?

Our findings

A person who used the service said, "I like coming here. The staff are nice. They are kind and look after me. The staff are all fantastic. I stay a few days at a time. I go to church. I like going to the church group." Relatives we spoke with told us, "It is the best it could possibly be. I am impressed with the care. They look after my relative very well. They have helped us as a family. The staff know and care about our relative and are like en extended family" and "I can only praise the service. We use both houses for respite, Leighton and Harelands. They have always been there to help us out. They have gone out of their way to help me." People and family members thought the service was good.

Staff we spoke with said, "I would recommend the home to family. It is a safe environment for them. We get a lot of good feedback from families and professionals. I love my job. I look forward to coming to work and helping people get the best out of their lives. The job is different every day and not monotonous. Different people to look after. I am passionate about my job. I am still learning and don't know everything. I would recommend this service to anybody. My children get involved. They join in with some of the activities. My daughter did her work experience at one of our services. I like working here." Staff were motivated and enjoyed working at the service.

A person who used the service said, "I can go out on my own and like to go for a walk. I make my own brew and look after myself mostly. I let them do the cooking they have to do something for me (joking)." Plans of care showed what level of support a person needed and what they could do for themselves. Training was provided to staff to help them have a clear idea about independence. People were encouraged to do things for themselves to remain as independent as possible including going out unsupervised and making their own drinks and meals.

A person who used the service said, "I sit in the dining room for meals but like my own space. They don't mind me having my own space. I keep to my same routines here as I do at home. I am cranky in the morning. I am not a morning person. They respect that. We saw that people were able to stipulate the gender of the member of staff they wanted and this was provided if possible. We also saw people's wishes were taken into account with regard to the delivery of their personal care. Relatives commented on how they appreciated how routines were followed which helped protect the dignity of people who used the service because they received the care they wanted. We saw that people were taken to their usual day centres for learning or maintaining life skills or attending activities.

Plans of care were developed with the person, family members and relevant professionals. This showed how the service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible.

There was a policy on equality and diversity. This gave staff information on how best to plan care for an individual. Plans of care took account of a person's gender, culture, language or communication method, religion and sexual orientation. There were various examples of how this was put into practice. People had a choice of staff, what they ate, how their religious needs were met and attended suitable activities.

Information was stored safely and securely. Records were kept in a locked office in cabinets and computer screens were not in public view. There was a confidentiality and data protection policy for staff to follow good practice. This ensured records were only seen by the staff who needed to have access to them and helped protect people's privacy.

We observed staff at various times during the two days. Staff were kind, caring and compassionate. People were taken out to places they wanted to visit and supported by staff to do so. We also saw there was a good rapport with a person who used the service who remained in the home all day due to the inclement weather. This person engaged with staff and the inspection process.

People's religious needs were taken into account and were able to follow their religion in the way they wished according to their ethnicity. One person told us they enjoyed going to church and used a local one when staying at the service.

Good

Is the service responsive?

Our findings

The service's aim was to provide regular, planned respite care for people who had been assessed as requiring it. However, the service responded to urgent requests for respite care. If the home was full the service used a local holiday company and provided staff in lodge type accommodation. This meant the people who used it had the care they needed but also remained local and could enjoy the activities they were used to. The service was therefore flexible in providing an emergency service that met people's needs.

A person who used the service said, "I work in a charity shop in Heywood. I like it there. I sort out donations and make tea and coffee. I also like football." Relatives we spoke with said, "There are plenty of activities." and "They [family members} enjoy coming here and always look forward to it. Their response shows us how they want to come here."

Staff had close relationships with day centres and colleges and attended meetings with them to discuss a person's needs. People were supported to attend them which ensured people's routines were followed and they did not lose out on activities or learning.

People had access to activities of their choice. People had been on a tram, to the pub, bowling, watching steam trains and going to museums or shopping. The service also had other activities on offer in separate locations. There was a building where people could join in various activities including making pottery, gardening, growing fruit and vegetables, cooking and arts and crafts. The activities coordinator said they had made chutney and sold it with the money put towards other activities. People were also able to learn pottery making skills and join in music sessions.

In another location there was a petting zoo and café. People could go there to socialise or join in activities which included getting involved with the animals. There was also a café at this centre and if people were able encouraged to help out.

People were taken to places of interest. This included going to a safari park, various parks for a walk, to the seaside, to play snooker or pool, pamper sessions, board games, music therapy, going to the gym and swimming. Sometimes there were parties in the home for people to enjoy. People had also been supported to go on holiday.

People were also assisted to learn life skills. We saw people were encouraged to cook, bake, tidy up communal areas, keep their bedroom clean and improve their abilities to care for themselves. Activities were meaningful and fulfilling.

We looked at two plans of care and saw they showed how the service met people's individual needs. People's choices, likes and dislikes where recorded for people to be treated as individuals. Plans were reviewed at each new admission and updated as required when people were staying at the home. We saw some reviews included people who used the service, family members, staff from the home and associated professionals. This ensured people's care was understood by all and therefore was consistent. If required

the review was also published in an easy read format to help people understand any changes.

There was a daily record which showed what a person had done and how they had been. This was a comprehensive record and any relevant information was passed on to other staff during a handover between shifts.

We saw that the service was developing a new care plan system which would be computer based. This was called Iplanit. The support officer who was helping to introduce the plan said, "The advantages of this system will be a more responsive ability of staff to react to the changing care needs of people who use the service. It will give managers a better insight into people's care package and will enable auditing to be much simpler. For respite this will be a much better type of handover. People who use the service will have access to a notepad system, or access the plans via their own personal computers. There will be access to it at the respite services, the day centre and people's own homes. The support officer (IT) will teach people and families how to use it. Each person will have their own access codes. Whilst families and people who use the service can add their own messages and media they cannot change the actual plan but comment if they think something could be better. People will have a privacy setting so only people they want to see it will be. People will be able to change photographs personal to them and personal preferences. This system will show how much more people can be involved in their care planning. We have started to use the system and some people's details have already been uploaded. We saw the development of the system so far and saw that this will involve people who use the service far more in their Care.

A staff member said, "We have a handover at the beginning of every shift and complete a communication diary to pass over important information." We saw the information was detailed and gave a good account of each person's day and was used to pass on information from one staff team to the next.

Information about how to raise a compliant was displayed at the service. It was written in an easy read format to help people to understand the process. There was also a version which told people how to complain, who to complain to, how the service would respond within timescales and the details of other organisations such as the Care Quality Commission. People who used the service and family members were able to bring their ideas or any issues they wanted. There had not been any official complaints but feedback forms supplied ways to improve We saw that from information supplied by families the medicines forms were improved for when people entered and left the home.

There was a weekly house meeting. We saw from the meeting people had been asked if there was anything they wanted to do. We saw from the meetings some policies and procedures were explained to people who used the service and the easy read format was used. We also saw people had enjoyed the cooking they wished to do and helping around the home.

The service sent out a satisfaction survey to people who used the service when they went home. People commented they liked their room, enjoyed their stay, enjoyed the food, liked the other people accommodated at the home, said staff were extremely nice and gave them plenty of choice. They also said where they had been which included swimming, horse riding, going to church, drives out, walking, eating out, shopping, helping with a BBQ and enjoyed another person's birthday party. One person said they could not fault their stay and would like to come again. Another person said the best thing about staying at Leighton House was staff being honest, doing activities and being given choice and independence. Improvement was that when the person books respite again she would like to know in writing and where she will be staying and this is not changed. Families all said that whilst they could not answer the questions their relative always came back happy and wanted to come back again. Feedback forms helped maintain and improve people's stay at Leighton House.

Outstanding ☆

Is the service well-led?

Our findings

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October 2014.

We spoke to a person who used the service who said they liked all staff and they would all respond. Relatives we spoke with said, "Overall we are more than happy. The staff are wonderful. Management are easy to talk to if you need them." and "There have never been any problems with staff. You can speak to the staff. You can contact the manager if you want. She has given me her own number. I am very happy with the care they get."

Staff told us, "I have settled in here and it is really good. They are very supportive. If you have any issues they will try to help you"; " The managers are approachable. They go out of the way to help you. It is a happy team here and we support each other. You can ring on call for support at weekends" and "Management are good with me. The managers are very supportive. We can get hold of people in an emergency."

The service trained some staff to be champions. These staff are taught specialist knowledge about a specific aspect of care and support. They were available to provide mentoring or advice in their areas of knowledge to other staff in the organisation. Staff were provided with a list of names and their roles to be able to contact them. Champions had been trained for Autism, equality and diversity, communication, dementia care, mental capacity and DoLS, moving and positioning, nutrition and safeguarding. This meant there were specialist staff to provide advice and guidance for many aspects of care the service provided and meet people's diverse needs. They also used this knowledge and expertise to improve practices in the service.

The service had a three year strategic plan which looked at difficulties facing the care industry, valuing people, ensuring people received good health and social care and setting goals. We saw the goals included the use of technology which had been commenced with the new plans of care which showed the service were working towards the plan.

Staff who wished were put on a succession plan. This meant staff could put forward their goals for the future. Management would through discussion and appraisal decide what training the staff member would need to achieve promotion to the post when available. A staff member said, "I want to become a support officer. I am going to join the career succession plan to do the training." Staff were encouraged to improve their career prospects within the organisation and given the guidance and training required.

Staff were offered incentives for good performance. A ceremony was held and awards given. We saw the categories and how staff were nominated. Staff we spoke with thought it was a good idea and got involved where they could.

The service had been nominated for the Skills for Care accolades which were due to be held in March 2018.

This meant the organisation had been recognised by an external organisation for their delivery of service. The service had signed up to the Social Care Commitment which is the care sectors promise to provide people who need care and support with high quality services.

The registered manager and other managers regularly audited many aspects of the service provided. Audits included health and safety, infection control, complaints, the environment including the maintenance of gas and electrical equipment, activities, menus, fire systems, safeguarding, accidents and incidents, care plans, daily records, finances and training. The audits were analysed by the registered manager and by managers at the head office. An action plan was produced to improve any areas managers thought was needed. The action plan document highlights which members of staff are responsible for completion and a date to be completed by. There was a coloured risk system to show if the action had been completed, was underway or not completed. From the audit we saw action had been taken to update policies and procedures, the implementation of the new plan of care and improved safety whilst people are out on activities.

There was weekly house meeting. This was produced in an easy read format and told us what had been discussed. Activities were discussed and had been tailored that week for the people who were accommodated. From the last meeting we saw people had gone to activities of their choice and been involved in running the home by helping with tasks. This showed the service ran a highly personalised service, tailored to individual needs and in accordance with their individuality.

The organisation held board meetings to discuss performance and the future. The board was made up of senior staff from PossAbilities and four family representatives. This gave people who used the service and their family members the opportunity to help drive the service forward. Discussion at the last meeting was around the proposed development of more supported living flats to bridge the gap between respite care, living at home and moving to more independent living. This initiative will be of benefit to people associated with the service and their future care provision.

There were various groups who met including the well-being group, a staff advisory group and a service user advisory group. The service user advisory group was open to staff, people who used the service and their carer's. From the meetings speakers had come in to talk about mental health and nutrition. Meetings helped direct the service in the way they wanted to move forward and included learning opportunities for staff.

There were regular further general staff meetings held around every six months. At the last meeting of November 2017 new staff were welcomed and discussions were held around medicines administration, taking photographs for the new IT system, keeping the house clean, handover books and handovers, keeping diaries up to date, house rules, incident and accident reporting, fire checks, not using mobile phones at work, use of PPE, not using social media and discussions around the care of people who used the service. Staff were able to have a say at the meetings which gave them a chance to say how the service was ran and helped increase their responsibilities in improving the service.

Senior staff also held regular meetings. We saw at the last meeting items on the agenda included budgets, business updates, complaints and compliments, recording of accidents and incidents, the staff situation including leavers and vacancies, promoting choice and control (this is the promotion of individual budgets for people who used the service), future developments, encouraging employment opportunities, improving the health of staff and better access to healthcare for people who used the service. Senior staff were kept up to date with the organisations aims and objectives

We looked at key policies and procedures and noted that many were produced in an easy read format. Easy read formats included how to complain, safeguarding, health and safety, finance safety, the mental capacity

act, confidentiality, relationships and sexuality, whistleblowing, privacy and human rights. All policies were up to date and gave staff and people who used the service good practice guidelines and procedures a how to do it guide. Guidelines to support staff were usually from an organisation known as the National Institute for Clinical Excellence. We saw this guidance for medicines, infection control and care in a residential setting. This guidance is considered to be good practice for services to follow.

There was a statement of purpose which told us who the provider was and key legal details and a service user guide to inform people who used the service, family members and professionals of the facilities and services provided.

We saw the service liaised with many other organisations including colleges, learning disability professionals, speech and language therapists, social workers, GP's and other medical professionals and advocates/independent mental capacity advisors (IMCA). An advocate is a person who acts independently to protect a person's rights and an IMCA acts in a person's best interests to ensure any decisions made on their behalf are the least restrictive. This showed how the service was able to keep people's health and social care needs up to date.

The service sent out a regular newsletter to keep people who used the service, staff and family members up to date with planned events and information about the service. At the last newsletter of January 2018 we saw items included looking at ways to reduce medicines for people with a learning disability, mental health issues and the champions, the role of the quality checkers and the board, explained how staff are putting themselves in the shoes of a person to experience what care is like to help produce ideas of how to make things better, recruitment, what active support means (helping people with all aspects of choice in their lives, activities and relationships) and ways to contact the service using public media. This information gave people who used the service key facts about the service and included them in the way they wanted to move forward and improve.