Achieve Together Limited

23 Pierrepoint Road

Inspection report

23 Pierrepoint Road
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
23 Pierrepoint Road is a residential care home providing care and support for up to 11 people who have a learning disability and may also have other health conditions, autism, mental health needs or physical disabilities. At the time of our inspection eight people were living at the service. 23 Pierrepoint Road is located in a residential area, similar in appearance to the other houses in the street. People had their own rooms and shared communal rooms such as the kitchen and lounge.

People's experience of using this service and what we found
During the inspection we found checks had been completed to help ensure people remained safe in the home. However, a potentially harmful cleaning product was not securely stored in one of the toilets.

People had COVID-19 risk assessments and care plans which identified measures to help keep people safe. Safe recruitment procedures were followed and there were enough staff to meet people's needs. Staff were supported to develop their skills and provide appropriate care through inductions, supervisions, appraisals, training and team meetings.

Right Support
The service supported people to have the maximum possible choice, control and independence and they had control over their own lives. People had a choice about their living environment and were able to personalise their rooms. Staff supported people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests. Staff enabled people to access specialist health and social care support in the community.

Right care
Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols could interact comfortably with staff and others involved in their care and support because staff had the necessary skills to understand them.

Right culture
People were supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people received compassionate and empowering care that was tailored to their needs. Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. People and those important to them, including advocates, were involved in planning their care. The service enabled people and those important to them to work with staff to develop the service. Staff valued and acted upon people's views.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
This service was registered with us on 1 December 2020 under a new provider and this is their first inspection.

The last rating for the service under the previous provider was good published in December 2020.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

This was a planned inspection based on the date of registration.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

23 Pierrepoint Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors. After the inspection, an Expert by Experience telephoned relatives for feedback about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
23 Pierrepoint Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager, deputy manager and care workers.

We reviewed a range of records. This included three people's care records and four medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with four relatives and another social care professional emailed us.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
• There was regular health and safety monitoring of the building, including the servicing of fire equipment, and checks had been completed to help ensure people remained safe in the home. During the inspection we saw the designated cupboard for cleaning materials was locked, however, we found a potentially harmful cleaning product that was not securely stored in one of the toilets. This was brought to the attention of the deputy manager who removed it immediately.
• People lived safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well. Records we reviewed showed risks to people were assessed and plans put in place to help reduce identified risks. Areas of risk assessed included choking, epilepsy, skin integrity, moving and handling and medicines.
• Care plans incorporated the identified risks and provided guidance for staff to meet people's needs. Staff we spoke with were aware of people's care plans and could explain people's individual needs.
• People had personal emergency evacuation plans (PEEPs) which indicated how each person should be evacuated safely in an emergency.

Preventing and controlling infection
• The provider had infection prevention and control procedures in place. People using the service had COVID-19 risk assessments and risk mitigation plans which identified specific risks to people to help keep them safe.
• Staff also had risk assessments and risk mitigation plans for COVID-19 which addressed their individual circumstances.
• The provider was in the process of recruiting domestic staff to support the care staff in maintaining hygiene standards. Staff had allocated cleaning tasks decided at each shift handover and completed a form to state tasks had been done. This included the cleaning of 'high touch' areas to help prevent the spread of COVID-19.
• The provider had enough personal protective equipment (PPE) and we saw most staff using it appropriately. However, we observed one staff member who was not wearing their mask correctly.
• Staff told us they had received infection control training and felt supported throughout the pandemic. One staff member commented, "I was furloughed. I couldn't fault them."
• The provider had implemented infection control procedures for visitors in line with government guidance. Visitors booked their visits in advance. On arrival they were asked to complete forms relating to COVID-19 and temperatures were taken upon arrival. Visitors were required to wear PPE as appropriate.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an

emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems and processes in place to help safeguard people from abuse and avoidable harm including appropriate policies and procedures for safeguarding and whistleblowing.
• When a safeguarding concern was identified the provider had worked with the local authority to address the issue and put actions in place to help prevent future reoccurrence.
• Staff had training on how to recognise and report abuse and they knew how to apply it.

Staffing and recruitment
• During the inspection we observed there were enough staff on shift to meet people's needs and keep them safe. We saw staff attending to people's needs and responding to requests for support. One person confirmed they thought there were enough staff to meet their needs. However, staff and relatives noted overall the service was short staffed and the registered manager acknowledged this.
• The service had recently lost a number of staff and the provider was in the process of employing new staff. At the time of the inspection, the provider was using regular agency staff to cover vacant shifts. Staff were aware of this and comments included, "They try and cover and get staff in. [It is] nice they are starting to use agencies; it takes the pressure off and they are recruiting permanent staff so it will be better" and "Only thing is we are short staffed, but we have a good team and everyone does what they can."
• The provider followed safe recruitment practices. Appropriate pre-employment checks including references from previous jobs and criminal record checks had been completed.
• Staff induction and training processes promoted safety, including those for agency staff. Staff knew how to take into account people's individual needs, wishes and goals.

Using medicines safely
• Medicines were administered safely, and the provider had policies and procedures covering the safe administration of medicines.
• The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles
• Staff had appropriate training including annual medicines competency testing. This was confirmed by a staff member we observed administering medicines.
• Records included information about people's prescribed medicines. Staff also had guidance on when and how to give people 'as required' medicines.
• Medicines administration records (MARs) were completed, including social leave. Where there were gaps this had been identified and addressed. On each shift there was a designated staff member to count medicines tallies during the shift to help monitor medicines were given as prescribed.
• Medicines were stored securely in people's rooms and maintained at safe temperatures.
• The provider completed monthly medicines audits to help ensure medicines were administered safely and errors were acted on and addressed.

Learning lessons when things go wrong
• People received safe care because staff learned from safety alerts and incidents. When incidents were reported, a root cause analysis was completed, and action taken to reduce the likelihood of it happening again. For example, an analysis recommended a sensor mat for one person and we saw this was implemented.
• Staff recognised incidents and reported them appropriately and managers investigated incidents and

shared lessons learned. For example, following on from an incident, people's risk assessments were reviewed and staff retrained in a specific area, as part of their learning from the incident and improvement of service delivery.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service had not had any new admissions since 2018, but the records we reviewed indicated people's needs and choices had been assessed before they moved to the service.
• People and relatives were involved in the assessment and care planning process. This meant staff had relevant information to support people with their choices.
• Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs.
• Care plans were regularly reviewed and updated to help ensure people received care and support appropriate to their current needs. Staff ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills.

Staff support: induction, training, skills and experience
• Training records confirmed staff had training that reflected the needs of the people they were caring for. Staff were able to explain how their training helped them to respond appropriately to people's needs. One staff member told us, "I have had [positive behaviour support planning] training for [person] about how to understand them and to find a way to de-escalate and keep everyone safe around them."
• The service checked staff's competency to ensure they understood and applied training and best practice.
• Staff received support in the form of continual supervision, appraisal and recognition of good practice. Supervision records we reviewed showed areas of work to improve on had been identified and training needs assessed.
• Staff said they felt well supported and had opportunities to develop professionally. One staff member said the provider had supported them to complete level three Health and Social Care training and this had given them confidence.
• People described staff as competent. One relative said, "They go above and beyond."

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to maintain healthy diets, and care plans recorded any specific needs, such as dietary requirements, equipment used, food preferences and dislikes.
• When required, people's nutritional needs and weight were assessed, and if needed a referral was made for additional support. For example, records indicated people were referred to the speech and language team and their recommendations were incorporated into the care plan.
• Mealtimes were flexible to meet people's needs and to avoid them rushing meals.
• People said they liked the food and one person told us they were supported to have culturally appropriate food. We also saw another person helping to cook and being involved in meal preparations. Comments

included, "Yes, it's delicious" and "Yes, I like the food."

Staff working with other agencies to provide consistent, effective, timely care
• The service had systems to support people to receive appropriate care and make referrals to other agencies when needed. A relative told us, "[Person] has regular access to an audiologist and physio."
• Care plans recorded people's healthcare needs and there was evidence the provider worked with other professionals including the GP and occupational therapist.

Adapting service, design, decoration to meet people's needs
• The home was an adapted house over three levels, which were accessible by a lift. People had their own rooms and shared communal rooms such as the lounge and kitchen. There was also an accessible garden. The provider planned to further develop the garden as requested by people at their residents' meeting.
• The new provider had made improvements to the environment of the home since the last inspection, and we saw evidence of repairs and decoration being completed which made the environment more comfortable and pleasant to be in.
• Most rooms were ensuite and were personalised by people to reflect their tastes. For example, one person had a favourite insect represented all over their room. Another person had signed football photos and a duvet cover with the logo of the team they supported.
• People could choose to spend time alone or in the communal rooms and we saw people moving around as they pleased.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to attend annual health checks, screening and primary care services.
• Records showed people were supported with their healthcare needs as required and staff made referrals to professionals accordingly. A relative confirmed this and said, "[The staff] asked for diabetic meals and they worked with the GP to manage [person's] epilepsy."
• People had care plans for specific conditions and health care needs, which provided guidelines to help staff deliver relevant care and to know who to involve if additional support was required.
• People had health passports which were used by health and social care professionals to support them in the way they needed.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• We found the principles of the MCA were being followed. People's mental capacity had been assessed and best interests decisions had been made appropriately and as required. When people had the capacity to consent to their care, we found consent had been sought.

• Staff knew about people's capacity to make decisions through verbal or non-verbal means and this was well documented.
• People were able to make day to day decisions and offered choices. A relative confirmed, "[Person] helps with cooking. Makes [their] own meals sometimes." Where appropriate families were involved in decision making. A relative told us, "[Person] can make their own decisions but appropriate guidance is given. They also phone [relatives] about decisions."
• Staff had received training around the MCA and obtained consent from people. For example, a staff member told us, "A few days ago [two people] re-applied for college courses. I printed out the different course choices and sat with them and showed them on the computer what new things were such as Mosaic, so they could decide if they wanted to try something new."
• Where necessary, the provider had made applications for DoLS authorisations so people's freedom was not unlawfully restricted. Two people with DoLs authorisations had advocates and the registered manager was supporting two other people to access advocates for specific issues. This helped to ensure people's wishes were considered.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People were treated with dignity and respect and were supported by staff who understood the needs of the people they were caring for. Comments from relatives included, "[Person] is treated with respect, also adjustments are made between privacy and safety" and "They really do care for [person]."
• Staff had completed equality and diversity training and knew the importance of respecting people's individual needs and protected characteristics.
• Care plans had information about people cultural needs and staff were aware of these. One staff member said, "Everyone has their culture they have in their care plan" and explained how they supported one person to attend their place of worship and knew what food was culturally appropriate for another person.
• Staff were calm, focussed and attentive to people's emotions and support needs such as sensory sensitivities. We observed staff comfort one person who was distressed, and after explained how they supported this person when they were upset. Another person told us, "Staff are kind, yes. Staff help me."
• Staff were patient and used appropriate styles of interaction with people. For example, one person used their own version of a sign language. Staff clearly understood what the person was trying to say to them and responded appropriately.

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives were involved in planning people's care and decision making. Care plans included information about people's preferences and dislikes and provided staff with guidance for meeting these. For example, one person's records indicated they could make their own choices regarding what they wore and what they wanted to eat and drink.
• Most people were able to communicate their wishes and we saw evidence of this in residents' meetings that discussed topics such as food, health and safety and going out. People also had one to one sessions with a key worker where they had the opportunity to discuss their care.
• Staff supported people to express their views using their preferred method of communication. One person did not have English as a first language. The service had two staff who spoke the person's language and key words were written down to help other staff communicate with the person so their wishes could be met. The service also worked well with the family to understand this person's needs.
• People were supported to access independent, good quality advocacy.

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity were respected, and staff encouraged people to maintain their independence.
• To help maintain one person's independence, they were enrolled in college programmes and encouraged to go to the shops themselves. A psychologist also provided input. Prior to the pandemic, one person was

supported into unpaid employment and worked in a shop.
• We observed that some people were encouraged to make tea for themselves and people were supported to be in charge of doing their own laundry.
• People's privacy was respected. One person told us, "Staff knock and come in." Staff also told us, "Each morning when I come on duty, I knock on their door and greet them. I also do the [residents'] meeting and we talk about respecting each other and treating [people] with dignity."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People received personalised care that was responsive to their needs in line with 'right support, right care and right culture' principles and were involved in planning their care.
• Staff spoke knowledgably about tailoring the level of support to individual's needs.
• Bedrooms were personalised with interests people enjoyed. One person had large family photos, who they regularly referred to in conversation and another had sensory items in their room. This included a large stock of different coloured play doughs and many cups or moulds they could use. One person said, "Love my bedroom" and another said, "Yes have all my own things [in my bedroom]."
• Care plans contained information relevant to people's day to day routines, preferences, dislikes and things that were important to them. People's background histories and information such as the person's culture, religion and preferred language were also recorded and promoted in their daily living. For example, we saw one person watching a religious service on a phone and another person said they had television channels in their language which they liked to watch.
• Care plans were regularly reviewed to help ensure information was relevant to meeting people's needs and preferences.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Staff ensured people had access to information in formats they could understand. People's communication needs had been assessed and there was guidance about how to communicate with people including how to understand people's non-verbal communication. For example, one person had buttons to press that said good morning and referenced what might be going to happen that day. They also had a key fob with various symbols that they could use when they went out. The person used their own hand signs and we observed staff understood these and responded to the person's requests.
• One staff member explained, "I communicate with [person one who] has their own words. I use [person two's] signs or [person three's] signs and I've learnt some Makaton signs. [Person four's] words are in [another language] so I have learnt a few words in their language."
• Information was provided to people in a format they could understand such as easy read.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
• People's activities were impacted by the pandemic as previously several people took part in activities in the community, which were slowly returning. During the inspection, we observed some activities in the home, but there was a lack of daily planned activities, particularly if people could not go out. We discussed this with the registered manager who said they would address it.
• Notwithstanding the above, there was evidence that people did participate in activities. Three people attended jewellery making online and we observed people doing beadwork. We saw pottery made by people and were told some people did inclusive cooking classes.
• The service had a comfortable lounge with a television and an activity room which contained games, DVDs, puzzles, beads, an electric keyboard, and sensory activities people could help themselves to. People told us, "I do wordsearch, colouring and I like clay. I love it here", "I like drawing. I like the beads. I like colouring. Yes, I can always do them whenever I want to" and "I like going exploring. I've been to [listed countries]."
• During the inspection, one person was at a day service, and others were asked if they wanted to go out and were supported to go out if they chose to. Other people watched television and talked with staff. We observed people, helping with various tasks which they appeared to enjoy, for example, putting things away, making tea, and folding clothes.
• People were supported to maintain contact with those who were important to them. Christmas and people's birthdays were celebrated and family were invited. Relatives confirmed they visited and told us, "We phone ahead to check they haven't got an appointment and do a [lateral flow] test before a visit. [Person] is coming home today for the weekend" and "Yes I get to see [person] whenever I like now."

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. People, and those important to them, could raise concerns and complaints easily and staff supported them to do so.
• Where there had been a complaint, we saw the provider responded appropriately. Comments from people using the service included, "I would tell the manager, yes [registered manager] would sort things out" and "Tell [registered manager]. I would speak up." Relatives said, "If there are concerns, we'll phone" and "I can't remember making a complaint. I know who their names are. We're kept in touch."

End of life care and support
• No one was being cared for at the end of their life, however, the provider completed end of life care plans to help ensure people's wishes and preferences for care at the end of their lives was known in the event they required this support.
• We reviewed some examples of end of life care plans and found they were undertaken with people and their families and contained a good level of detail.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service was person-centred and open. People and most relatives indicated they were satisfied with the care provided.
• Management were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. The registered manager told us that everyone was encouraged to speak up and be involved in decision making.
• Several people commented about how they would speak with the registered manager if they were unhappy and said they were sure the registered manager would respond if there was a problem. We observed people going into the office on a regular basis. This included people who used sign or use body language instead of words to express what they wanted.
• Care plans were person centred with guidance to help achieve good outcomes for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their responsibility around the duty of candour and was transparent in sharing information. When an incident occurred, the registered manager had contacted the relevant agencies and the family.
• The provider had responded to complaints and concerns and kept the relevant parties informed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider had management and staffing structures in place. The registered manager had the skills, knowledge and experience to perform their role and a clear understanding of people's needs and oversight of the services they managed. They were supported by a deputy manager and attended meetings with other managers from the organisation.
• The provider had processes to monitor the quality of services provided and make improvements as required. This included checks of care records, medicines and safety checks. Reports were also sent to the provider which provided an additional level of monitoring for the service.
• Staff said they were well supported by the management team and spoke positively about the new provider. One staff member said, "I think we have done well this past two years. A very hard two years got through with an amazing team and good management."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider sought feedback from people and those important to them and used the feedback to develop the service.
• Regular residents' meetings were held to give people the opportunity to say how they would like to see the home run. Topics included health and safety, safeguarding, food and activities. Staff meetings were held monthly to share information and provide feedback.
• The provider also sent out satisfaction surveys. A service development plan and stakeholder survey review with an action plan was last completed in January 2020 and revised in November 2020.
• People, staff and most relatives said the registered manager was approachable and responded to people's concerns. Comments included, "[The deputy manager] is very good. I tend to go to them. [The registered manager] is also good."
• Care plans recorded people's protected characteristics and provided guidance for how to support these. For example, supporting people to attend their place of worship and staff being able to communicate with people in their first language.

Continuous learning and improving care
• The provider had systems for assessing, monitoring and mitigating risk and improving the quality of the service. These included checking medicines, health and safety and care plans.
• The registered manager was committed to making improvements to the service and told us there had been a lot of learning after a specific incident. This included reviewing everyone's risk assessments and working with the physiotherapist and occupational therapist to make improvements for people using the service.
• The registered manager also noted that since the last inspection the new provider had undertaken repairs and the environment had been improved.

Working in partnership with others
• The provider worked with a number of professionals to help ensure people's needs were met. This included working with the speech and language team, the community learning disabilities team, occupational therapist, GP, social workers and local colleges. Working with other professionals had resulted in positive outcomes for people such as a moulded wheelchair, sensory mats and epilepsy pillows.
• Two social care professionals noted, "They are responsive" and "All the required information was ready to me to view on arrival. [The registered manager] contacts the department as needs be."
• The provider was involved in provider engagement groups organised by the Local Authority which aimed to help improve care services in the local area.