Voyage 1 Limited

Elliott House

Inspection report

Rotherham Road
Great Houghton
Barnsley
South Yorkshire
S72 0EG

Tel: 01226756319
Website: www.voyagecare.com

Date of inspection visit:
23 March 2016

Date of publication:
11 May 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Elliott House is a care home registered to provide accommodation and personal care for up to 6 people with learning disabilities. Each person has their own bedroom with en-suite facilities. The home is situated within the village of Great Houghton, near Barnsley. The home is owned by Voyage 1 Limited.

This inspection was carried out on 23 March 2016 and was unannounced. We previously visited the service on 01 May 2014. We found that the registered provider did not meet all of the regulations we assessed. We carried out a follow up inspection on 23 July 2014 and found that the registered provider had met the regulations.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC).. 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. The registered manager was also registered to manage another of the registered provider's services. They divided their time equally between the two services.

We found that the recording of accidents and incidents was inconsistent and did not always provide sufficient detail about the incident and what action had been taken following the incident to prevent a reoccurrence. We made a recommendation about this in the report.

We saw that medicines were obtained in a timely way so that people did not run out of them, stored securely, administered on time, and disposed of appropriately. However, we found that the recording of medication was inconsistent and medication audits did not occur as scheduled. We made a recommendation about this in the report.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's assessed needs. Staff had been employed following appropriate recruitment and selection processes.

We found assessments of risk had been completed for each person and plans had been put in place to minimise risk.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the service deemed essential such as safeguarding, infection control, safe handling of medication, manual handling and the management of actual or potential aggression (MAPA).

The registered manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the

Mental Capacity Act 2005 (MCA) guidelines had been followed. Emotional or behavioural support plans were in place for most people using the service.

People's nutritional needs were met. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day.

People were well cared for and we saw people were supported to maintain good health and had access to services from healthcare professionals. People had health action plans in place to help ensure their health needs were met.

We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the home. People were supported to make choices and decisions regarding their care.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences and likes and dislikes, and contained detailed information about how each person should be supported.

People were offered a variety of different activities to be involved in. People were also supported to go out of the home to access facilities in the local community.

The registered provider had a complaints policy and procedure in place and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments or suggestions were appropriately actioned.

We found the registered provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support. The service was clean, tidy and free from odour and effective cleaning schedules were in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The recording of accidents and incidents did not always provide sufficient detail. It was not always clear what action had been taken following an incident to prevent it from reoccurring.

The home had a robust system in place for ordering, administering and disposing of medicines. However the recording of medication was inconsistent and audits had not taken place as scheduled.

Staff displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Risk assessments were in place and reviewed regularly, which meant they reflected the needs of people living in the home.

Is the service effective?

Good

The service was effective.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act 2005 (MCA) guidelines were being fully followed.

People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day.

People who used the service received, where required, additional treatment from healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw people were encouraged and supported to take part in a range of activities.

There was a complaints procedure in place and people were encouraged to comment on the quality of the service they received.

Is the service well-led?

Good

The service was well led.

The service had effective systems in place to monitor and improve the quality of the service.

People told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Elliott 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 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 was carried out on 23 March 2016 and was unannounced. One Adult Social Care (ASC) inspector carried out the inspection.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR in the agreed timescale.

The people who used the service had complex needs which meant that not all could tell us their experiences. We used a number of different methods to help us understand the experiences of the people who used the service including the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experiences of people who were unable to speak with us.

During the inspection we spoke with three members of staff, the deputy manager, one person who used the service and a healthcare professional. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people,

handover records, the incident / accident book, supervision and training records for three members of staff, staff rotas and quality assurance audits and action plans.

Requires Improvement

Is the service safe?

Our findings

The registered provider had policies and procedures in place to guide staff in how to protect vulnerable people from the risk of harm or abuse. We saw that safeguarding concerns were recorded and submitted to both the local authority's safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents.

During conversations with staff it was clear they were aware of the different types of abuse that may occur and what action to take if they witnessed abuse or poor care. A member of staff said, "I've done my safeguarding training and we talk about what to do if we see anything of concern" and "If I saw anything that concerned me I would speak with the manager, the ops [operations] manager or I could whistle blow and go straight to the safeguarding team." The service's training matrix showed staff had completed training in how to safeguard vulnerable people from abuse and they had also completed an accredited management of actual or potential aggression (MAPA) training course. These measures provided staff with the knowledge they needed to ensure people were protected from abuse.

We saw that systems were in place to ensure that people's finances were appropriately managed. The registered provider acted as appointee for three of the people living in the home and this enabled them to collect and manage people's income. Any large purchases would require the approval of the registered manager, operations manager and also a member of their family (or in one case, an advocate). Other people's finances were managed by their families and money was deposited into their account to ensure they always had funds available. We saw one example where a family member had been consulted prior to the booking of a holiday for one of the people using the service. Financial records showed us that all transactions in and out were recorded and a running balance of funds was kept. The balance was checked following each transaction and records were audited regularly to ensure they balanced and all money was accounted for.

Care plans contained risk assessments that were individual to each person's specific needs. We saw that the registered manager also ensured that day to day risks were minimised through the completion of various environmental checks. Personal Emergency Evacuation Plans (PEEPs) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed us that the registered manager had taken steps to reduce the level of risk people were exposed to.

Accidents and incidents that took place within the service were investigated and we saw some systems were in place to reduce reoccurring events. A member of staff told us "Any accidents or incidents all need reporting. There are forms we have to complete for the manager to review." We saw these were audited weekly by the quality and compliance manager and operations manager to ensure they were fully completed and graded for significance. We were told by the operations manager that these were then escalated within the organisations so all levels of management were made aware of any serious incidents and an appropriate plan of action could be implemented.

We reviewed incident records and found that the standard of recording was inconsistent. We saw when staff had been required to use MAPA techniques the incident reports did not always provide sufficient detail. We saw some incident reports simply stated 'MAPA techniques used' and listed the members of staff involved and the location of the incident. There was no detail regarding the precise MAPA technique that was used, whether it was a physical intervention or whether the de-escalation element of MAPA was sufficient to resolve the issue, and there was no indication of how long the intervention had lasted. We also saw that the terminology used in the incident reports could be deemed oppressive. For example we saw that people were 'taken' to their room or 'removed from a room' without any additional information to clarify how this had been done and whether the person was compliant at the time. We discussed this with the deputy manager and the operations manager and they told us that they had stressed the importance of accurate incident reporting with staff in the past. We also discussed some of the incidents with staff and they confirmed that the term MAPA covered physical, verbal and environmental interventions. The operation manager provided reassurance that the quality of incident reporting would again be addressed with the services staff.

We checked three staff recruitment files and saw that appropriate checks were completed before staff commenced working within the service. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them.

People who used the service had their assessed needs met by sufficient numbers of adequately trained staff. A dependency tool was utilised by the registered provider to ensure appropriate numbers of staff were deployed at all times. We saw that people's care needs including the support they required with personal care, eating and drinking, bathing, participating in activities and attending healthcare appointments were calculated within the dependency tool to determine the number of staff needed. Some people required one to one support to ensure their needs were safely met and to help avoid any escalation of behaviour when they displayed signs of agitation or distress, and this was being provided. A visiting healthcare professional told us "There used to be a much higher turnover of staff at the home but the staff are more consistent recently and the home has improved as a result."

The registered manager monitored the maintenance of the building and premises with support from the registered provider's property manager to ensure that the premises and all equipment were checked in line with current guidelines. We saw that any damaged, broken or dangerous equipment was reported to the property management team, prioritised and then repaired or replaced at the earliest opportunity. We viewed documentation and certificates that showed us that the relevant checks in relation to fire safety, utilities, ceiling hoists and bath temperatures had been completed within the stipulated timeframes. This ensured they were safe and in good working order. The home had a current fire safety policy and procedure, which clearly outlined what action, would be taken in the event of a fire. A fire safety risk assessment had been carried out so that the risk of fire was reduced as far as possible. We saw that regular fire drills were carried out which helped prepare staff to respond appropriately in the event of fire

We viewed the registered provider's training records and saw that all staff apart from one had up to date safe handling of medication training. This meant that 'as and when required' medication such as pain relief could be administered at any time during the day or night. The deputy manager told us that competency checks were completed annually on established staff and three times per year on new members of the staff team.

We looked at how medicines were managed within the home and checked four people's medication administration records (MARs). We saw that medicines were obtained in a timely way so that people did not run out of them, stored securely, administered on time, and disposed of appropriately.

We checked peoples MARs and found that most were fully completed, however we saw there was two missing entries for the same medication on one record and there was no explanation given. We carried out a stock check and found that the amount of medication tallied with the amount administered, indicating that all medication was accounted for and this was a recording issue.

Each person had a medication profile/history file and this included individual guidelines for medicines prescribed 'as and when required' (PRN), which safeguarded people from the risk of medicines being administered outside of those guidelines. We saw a PRN protocol was in place and provided information about each medication and under what circumstances it should be given. Staff were also required to provide the reason that the medication was administered and also record what the outcome was, including whether the medication was effective. We saw that when PRN medication was given this was countersigned by another member of staff, however we found that the outcome was not always recorded. This information would be useful to monitor the effectiveness of the medication and would be beneficial during medication reviews. We saw that stock checks of PRN medication were completed on a daily basis, however we saw that although this had been completed it had not been recorded on the correct document, we also noted one of the documents did not contain any dates.

Some people who lived at Elliott House had been prescribed controlled drugs (CDs); these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was a suitable storage cabinet and staff were recording the administration in a CD record book. We checked a sample of CDs held against the records in the CD book and found that these balanced.

We were told one person had their medication given to them covertly. Covert administration of medicines is only used when medication needs to be given in a disguised format, for example in food or a drink. It is administered without the knowledge of the individual and only when the decision to administer medication in this manner has been discussed and agreed with those involved in their care and has been deemed to be in their best interests. We saw that a covert medication pathway was in place and had been signed by all relevant individuals including the person's consultant, community nurses, the pharmacist and the person's next of kin.

We saw from the auditing schedule that that medication audited monthly and that stock checks were recorded on a daily basis. However when we viewed the medication audits we found that they had not been completed since December 2015. This meant that any errors would not have been detected and no action corrective action would have been taken.

During the inspection we found the home to be clean, tidy and free from odour. Infection control audits were completed on a monthly basis and we saw that there was detailed information available for staff on hand washing and what to do in the event of an outbreak or suspected outbreak of an infectious disease within the home. Cleaning schedules included daily, weekly and deep cleaning tasks to be completed by the staff. This showed us that the registered manager had considered the impact of infection for people in the home and had put interventions in place to minimise this risk.

We recommend that the registered provider take steps to ensure that all incidents within the home are accurately and thoroughly recorded, including physical and non-physical interventions carried out by staff.

We recommend that the service follows their policies and procedures on the administration of medication, including recording and auditing.

Good

Is the service effective?

Our findings

We saw that all new staff completed an organisational induction, which included the shadowing of more experienced staff and the completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives. It covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Staff were only able to work alone following completion of the Care Certificate. A member of staff told us "When I started I had to do a two week induction which involved me doing lots of different training and I then shadowed more experienced members of staff" and "At the end of my induction the manager asked me if I felt confident to start on shift and I was then included on the rota." We saw that regular reviews were held during staff probationary periods to monitor how they were adjusting to the role, discuss any concerns and check levels of competency.

Staff had completed a range of training pertinent to their role and we saw this was delivered through distance learning packages and also through face to face training for topics that required 'hands on' knowledge, such as manual handling and management of actual or potential aggression (MAPA). The training record showed staff (including bank staff) had completed training in a range of subjects including equality and diversity, fire training, food safety for support workers, health and safety awareness, infection control, mental capacity act and DoLS, nutrition awareness, safeguarding adults at risk, first aid and allergen awareness in care. This meant that staff had the required skills to effectively meet the needs of the people using the service

Staff were supported during on-going supervisions and team meetings. We saw that staff meetings were used as a forum to discuss budgets, rotas, health and safety and the needs of people using the service. A member of staff told us "We have supervision and can discuss any concerns, any training we need, and whether we have any issues or concerns with service users or other members of staff."

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation, which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The 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. We found that the registered manager was aware of their responsibilities in relation to DoLS and had made applications to the local authority for

four of the people using the service, which had been granted. This helped to ensure people received care and support in the least restrictive way.

During conversations with staff it was clear they had a good understanding of the principles of Mental Capacity Act 2005 (MCA) and the need to gain consent before performing any care interventions. Staff told us "It doesn't matter whether a person has capacity or not, I always ask people if they are happy for me to carry out whatever the task is before I start" and "I always talk them through each step of what I am doing." We viewed care files and saw that best interest decisions were made when appropriate and all the relevant documentation had been completed and signed by people involved in the decision.

Each person had a decision making profile that provided details of what decisions the person was able to make for themselves, which decisions they required support to make and which decisions were made on their behalf. The plans included how the person liked to be given information, how to present choices to help them understand and what time of day is best for the person to make decisions. This ensured that when a decision needed to be made the person had been supported as much as possible to make their own decisions

We discussed the use of restraint in the service and were told that although physical intervention was sometimes needed it was always used as a last resort. We saw that people had behaviour and emotional support plans in place and these provided detail in relation to how best to respond when people displayed behaviours that challenged the service. Staff we spoke with all agreed that the new MAPA training was an improvement on the old non-violent intervention training they received. One member of staff told us "It's all about de-escalation and managing the environment – the holds are easier to use as well." We saw MAPA clinics were held within the home and these provided staff with an opportunity to practice the techniques they had learnt during training and also ask any questions or discuss previous incidents they had been involved in.

People were supported to maintain a balanced diet. We saw that people chose what they wanted to eat and were encouraged to consider healthy options. A member of staff told us "We have a weekly house meeting and the menu is always on the agenda." Staff had completed training on food and nutrition and told us that they always tried to ensure the people they supported maintained a balanced diet and that they encouraged them to make healthy choices.

We found detailed plans were in place for mealtimes and food, and people's nutritional requirements were also considered. People were weighed regularly to ensure any issues with their weight were recognised and action could be taken. We saw that when weight loss was identified referrals were made to the appropriate professionals for a full assessment of their needs. We noted that weights were often recorded in different measurements which made it more difficult to quickly calculate whether a person had experienced weight loss or gain.

People had access to a range of health and social care professionals to meet their needs, including GPs, dentists, psychologists, psychiatrists and specialist nurses. Referrals were made quickly when people's needs changed and we saw people were supported to attend health appointments and hospital admissions. A visiting healthcare professional also told "The staff are more than happy to call me and ask for guidance. They have my mobile number and if anything has happened over the weekend they will leave a message so I can pick it up first thing on Monday morning." This provided assurance that people's healthcare needs were consistently met.

Good

Is the service caring?

Our findings

On the day if this inspection we found the service to be calm, relaxed and homely. Music was playing and people were free to go about their daily lives as they wished. We observed good interactions between staff and the people living at the service and saw that they clearly knew people well and understood how to best respond to their needs.

Throughout the inspection we observed staff treating people with kindness and compassion. Staff spoke to people in a friendly way and it was clear that the people who used the service were comfortable in their surroundings due to the trusting and supportive relationships that had been built. We saw that when people became distressed staff were quick to intervene and they knew that by refocussing a person's attention they could help reduce anxiety and avoid an escalation in behaviours that may challenge the service.

People's independence was promoted. A member of staff told us "We always try and promote people's independence. We have just had the kitchen refitted in [name of a person using the service] room and bought a new table and chairs and some new cutlery so when they invite their friends around they have somewhere to sit and enjoy a meal together" and "We try and provide just the right amount of support to enable people to help themselves." We were also told that staff supported some people to make their own meals and encouraged people to keep their rooms tidy and complete laundry tasks if they were able.

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bedroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified situation. They also ensured that they did not provide any care considered to be personal in the communal areas and carried out private conversations away from other people.

People were listened to and their choices were respected. We saw regular house meetings took place and key workers were invited to people's reviews to ensure their views were heard. Staff told us that people's care plans provided clear guidance on how to effectively communicate with each person using the service. They also told us that one page profiles were a useful tool when learning about people's likes and dislikes. Staff explained they had developed their own techniques to ensure they were able to communicate with people and ensure they were offered a choice. One member of staff told us "I always offer people a choice and if they can see the choices then they can usually decide for themselves what they want" and "It's also important not to overload people with too many choices as this can just cause more confusion." Another member of staff said "We have a good idea what people like now, but we still offer a choice as people might change their minds." When staff found a method of communication that worked they added this to the care plan to ensure that information was shared with all staff.

People were allocated key workers who attended monthly key worker meetings, supported people to access the community, arranged days out and holidays and were responsible for ensuring that people's care files were kept up to date. Key workers also ensured that important dates including family and friends birthdays were recorded to ensure that cards were sent if it was identified this was important to the person.

Good

Is the service responsive?

Our findings

Support plans had been developed from information gained during initial and on-going assessments, discussions with people's relatives and from observations made by staff when they were supporting people. Each support plan was written in a person centred way and included people's preferences, detailed information in relation to the level of support people required and what tasks people could carry out independently.

We saw care files contained a range of person-centred tools to help describe who the person was, what their likes and dislikes were, how best to support them, what was important for the person and how staff could effectively communicate with them. These tools included life histories, one page profiles, relationship maps and communication passports.

People's health concerns were documented in 'health action plans' along with the current support they received and future appointments with relevant healthcare professionals. This provided assurance people's diverse health care needs were met responsively. GPs, community learning disability nurses, psychologists, opticians and dentists were other professionals that contributed to the care of the people who used the service. We saw that 'health action plans' were reviewed on a monthly basis.

A visiting healthcare professional told us that they had been involved in the development of care plans for people using the service. People who used the service or those acting on their behalf were involved in reviews of their care when possible. We saw reviews were conducted on a regular basis and a key worker meeting occurred monthly. Discussions in these meetings included complaints or suggestions, what's working / not working, any new purchases, medication changes and what was important for the person concerned. A member of staff told us, "We review the care plans weekly which helps us stay on top of things."

We saw that emotional and behavioural support plans were in place for all but one of the people using the service. Where possible, people had been involved in the development of these plans and when people were unable to contribute, the reasons had been clearly recorded. The plans explained why support was needed, discussed any potential triggers, advised how staff could recognise a person was becoming anxious, what the potential outcome was and for staff to question whether physical restraint was needed. We noted that one person's emotional and support plan was missing from their file. We checked records and found that this person had been involved in incidents which had required non-physical interventions. We discussed this with the 'stand in' deputy manager and also the regional operations manager who both agreed the support plan should have been in place to provide people with clear guidelines on how to effectively manage the person's behaviour. They asked the key worker to implement this with immediate effect.

Staff supported people to take part in a range of activities to meet their social care needs including attending holidays, social clubs, lunch events, exercise and trips to the shop. People were encouraged to develop new and maintain existing relationships with people who mattered to them. People maintained contact with their families and friends; we saw one person regularly visited another person who lived at one

of the registered providers other homes to either cook each other a meal or go out for the day / evening. We saw evidence that people's birthdays were special occasions and the persons key worker was responsible for ensuring that cards and gifts were purchased. We also saw that annual events including Halloween, Christmas and Easter were celebrated within the service.

A member of staff told us the registered provider had just changed the services vehicle and that the new one was much bigger and would enable staff to take more people out together. They told us they were looking forward to some trips out to the coast when the weather improved. One person who used the service told us "I like to go out to bingo and also enjoy shopping" and "I am looking forward to my birthday, we can have a party."

The registered provider had a complaints policy and procedure in place and we saw that this was displayed throughout the home, with 'see something, say something' posters and forms available for people to use. We spoke with one person who used the service and they told us they would talk to staff if they had anything they wanted to complain about. We reviewed the complaints file and found the last complaint was recorded in June 2015 We saw that this was thoroughly investigated by staff, escalated to the appropriate organisations and the person making the complaint had received an outcome letter information them of the findings. This showed that the registered provider took people's complaints and concerns seriously.

As some of the people using the service would be unable to make a formal complaint, the registered manager had ensured there were other opportunities to capture their views. We saw that regular service user and key worker meetings were carried out and that people using the service also completed an annual quality assurance survey.

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since January 2015, although they were absent on the day of this inspection. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Although the registered manager was absent on the day of the inspection, staff told us they felt well supported by them and that they were able to approach the registered manager with any issues or concerns they may have. One member of staff said "If I have any issues I can talk it through with a senior or one of the managers. All of the managers are really good."

The 'stand in' deputy manager told us they worked closely with relevant healthcare professionals such as the speech and language therapy team, learning disability nurses and psychologists to ensure people received care and treatment in line with best practice guidance. A visiting health care professional told us the registered manager and staff had developed good relationships with community teams and relevant organisations. They said "We have worked well together to ensure that people's needs are always met." They told us that they had made special arrangements for a person to have a procedure carried out at the hospital and that, although it took a significant amount of planning and involved several different services, the procedure was able to be successfully completed.

The registered provider had a clear vision, set of values and a mission statement. It stated 'Our mission is to deliver world class outcomes for people with disabilities in the highest quality residential homes by providing innovative, flexible and individual support.' To help them achieve this we saw there was a quality monitoring system in place that consisted of weekly, monthly and annual audit tasks, meetings and questionnaires. Information collated from these was analysed and action plans were produced to address any areas identified as requiring improvement. However, we did note that medication audits had not taken place as scheduled with the last one recorded in December 2015. We were reassured this would be addressed immediately.

In addition to the audits completed by the registered manager, the registered provider's operations manager also completed quarterly checks within the home. We saw the 'consolidated action plan' helped to drive improvement by identifying any areas of the service where improvements could still be made. We saw these reflected the CQC's five questions of Safe, Effective, Caring, Responsive and Well-led and provided specific actions for the service's staff to carry out. They identified who was responsible for ensuring the action was completed and this was 'signed off' once accomplished. This showed that the registered provider's senior management team were sharing the responsibility for the service's performance.

House meetings took place and we saw that four people had attended the last meeting in February.. We saw an update was provided from actions identified at the previous meeting and that new curtains had been provided in the kitchen. We saw that issues were discussed including the redecoration of the sensory room

and the need to book a holiday for one of the people using the service. These issues had been identified as actions and allocated to specific people to ensure they were followed through. People were asked if they had any complaints and staff had recorded that people indicated that they liked the staff who worked at the home and they knew they could speak with the manager regarding any concerns they may have.