Westwood Care Group Limited

Dales House

Inspection report

304 Cottingham Road
Hull
East Yorkshire
HU6 8QA
Tel: 01482343601
Website: www.westwoodcaregroup.com

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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**

Overall summary

We undertook this unannounced inspection on the 22 and 23 April 2015. This was the first inspection since the service was registered with the Care Quality Commission on 10 October 2014.

Dales House is situated in a residential area in Hull and can provide accommodation and personal care for up to seven people who have primary needs associated with learning disability. The service has seven single bedrooms, two sitting rooms and a dining room. There are sufficient bathrooms and shower rooms to meet people's needs and all areas of the service are accessible to people with mobility difficulties. One of the seven bedrooms is available to accommodate people who require respite care. The service is new, within its first six months of registration, and at the time of the inspection there was one person who lived at the service. Another person was in the process of moving to alternative accommodation as the service was unable to meet their needs. Some people used the respite service at intervals and one person received a day care service.

The service has a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

Staff were generally recruited in a safe way but there had been one occasion when full checks had not been received prior to the start of employment. We found there was sufficient staff employed to support the people who used the service and they received induction, training, supervision and support.

People received their medicines as prescribed but we found improvements were needed in some aspects of recording of medicines. We saw one person had not required any medicine to calm their anxiety, which had been an improvement for them.

The heating and hot water system in place helped to minimise the risk of Legionnaires disease but there was no routine to flush through unused hot water outlets and shower heads. This was needed in the bedrooms and any other areas currently unused to help prevent the spread of legionella infection. We found all areas of the service were clean and tidy.

We found people lived in an environment that was safe. There were policies and procedures to guide staff in how to keep people safe and risk assessments were completed. These included guidance for staff in how to minimise risk whilst still ensuring the people could make decisions. Staff knew what to do to keep people safe from the risk of harm and abuse.

We found people's health and nutritional needs were met. They had access to a range of health professionals for treatment, advice and support. The food prepared looked well-presented and people were provided with choices and alternatives.

We found staff followed the principles of the Mental Capacity Act 2005 and when people were assessed as not having capacity, meetings were held to discuss options for their care in their best interest. We also found the registered manager had made appropriate applications to the local authority when they felt people had been deprived of their liberty.

The building had been adapted to meet people's needs and there was equipment to help them access all areas.

We observed staff interacted positively with people they supported. They spoke with people in a kind and caring way and respected their privacy and dignity. Health and social care professionals described staff as professional and skilled.

People's needs were assessed and care plans were person-centred. Staff confirmed they had time to read care plans and it was clear via discussions with them that they knew people's needs well.

We found information was provided to people in a format that met their needs. The surveys which formed part of the quality monitoring system need to be further developed to make them more accessible to people who used the service.

There was a quality monitoring system but this was still in the early stages due to the new status of the service. Although auditing documentation was available this had yet to be used to test out specific areas of the service.

The registered provider had developed an open and inclusive culture where staff and people who used the service felt able to raise concerns and make suggestions.

Summary of findings

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 consistently safe.

People received their medicines as prescribed but recording of medicines could be improved to ensure there is full guidance for staff when administering 'when required' medicines.

The recruitment process was generally robust, however on one occasion, all employment checks were not in place prior to the person staring work.

Although the service was very clean and tidy, some improvement was needed to ensure all precautions were taken to prevent the spread of legionella infection.

There were sufficient staff on duty and they knew how to protect people from the risk of harm and abuse.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met. They had access to a range of community based health professionals when required.

Staff received an induction and had access to training. There were supervision, appraisal and support systems in place for staff in order for them to feel confident when supporting the people who used the service.

The service was meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards. Staff understood how to protect the rights of people who had limited capacity to make decisions for themselves.

The service had been adapted to meet the needs of the people who lived there.

Is the service caring?

Good

The service was caring.

People received care and support from staff in a kind and professional way. We found staff were passionate about the work they completed and continually strived to improve the service for people.

People were treated with dignity and respect. They were supported to maintain contact and relationships with their families.

The service had developed ways to improve communication methods for people who used the service. This helped to involve people and provide them with information so they could make choices for themselves and achieve a measure of independence.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans were person-centred. Staff knew people's needs well and delivered the care in a person-centred way.

There was a range of activities and meaningful occupation for people to participate in within the service. We saw people accessed a range of community facilities to help them have an active social life.

There was a complaints policy and procedure which was in an accessible format to meet the needs of people who used the service.

Is the service well-led?

Good

The service was not consistently well-led.

There was a quality monitoring system in place but this had not been fully developed yet due to the new status of the service. Staff and management listened to people and had improved their care and support where necessary.

The registered manager provided good leadership and had sound values which had filtered through to the rest of staff team. This had impacted positively on the way people were supported to ensure they could reach their goals and potential.

The staff worked as a team and communicated well with each other.

Dales 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 by one adult social care inspector and took place on 22 and 23 April 2015. The inspection was unannounced.

Before the inspection, the registered provider completed a Provider Information Return [PIR]. 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 PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection we spoke with the local authority responsible for commissioning placements at the service, the local safeguarding team to see if they had concerns and a social worker involved in supporting one of the people who used the service.

During the inspection we observed how staff interacted with people who used the service. We spoke with one person who was using the service and their relative. We also completed a short observation for inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We had discussions with the registered manager, a senior support worker, two care support workers, two social workers and a health care professional. We also spoke with the heating engineer who fitted the boiler and heating system.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as their medicines administration records.

We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rotas, shift handover records, minutes of meetings with staff, surveys, checks and maintenance of equipment records.

We completed a tour of the building to look at how hygiene and cleanliness was maintained.

Requires Improvement

Is the service safe?

Our findings

One person who used the service told us they felt safe staying there for respite breaks. A relative told us, "They really couldn't do anything better." During the short observation for inspection [SOFI] we observed staff support a person to remain safe in an outdoor area, whilst participating in specific activities. A visiting social care professional said, "They keep people safe."

We saw staff were generally recruited in a safe and appropriate way. Application forms were checked, references obtained and interviews held. Checks were made with the disclosure and barring service [DBS] to see whether staff were appropriate to work with vulnerable adults. However, we saw in one instance that advice from the DBS regarding the timing of an offer of employment had not been heeded. The reply from DBS indicated an offer of employment should be delayed until the return of the check. The issue related to minor and historical information included in the DBS return and we spoke with the registered manager about this. They told us they had discussed this with the member of staff and the provider but they had not recorded the discussions. This meant it was difficult to audit decision-making regarding the issue; the registered manager told us all discussions would be recorded in future.

The heating engineer told us the service had stored hot water which was in a sealed pressurised boiler system to help prevent the spread of legionella infection. However, we saw there was no risk assessment for Legionnaires disease and no system to flush through unused hot water outlets as part of a risk management plan to prevent the spread of legionella infection. The registered manager confirmed this would be added to the checks made on hot water outlets. We saw hot water outlets were fitted with thermostatic monitoring valves and checks were made of them to make sure the hot water remained at the correct temperature. Equipment used in the home was checked, serviced and maintained in line with manufacturer's instructions.

The service had a domestic washing machine and drier. We asked the registered manager to check with the manufacturer to ensure the machine could launder linen in line with the provider's laundry policy and take action to review the use of domestic washing machines if there was a concern. At present the washing machine was not required to launder soiled linen but this may change in the future.

People received their medicines as prescribed. We saw medicines were obtained, stored and administered safely but recording could be improved. For example, some medicines administration records had been changed following a discussion with the prescriber but the changes were not signed and dated which could cause confusion to staff. The way staff completed entries of medicines received into the controlled drugs book were confusing. We also saw one medicine, which the registered manager stated had been returned to the pharmacy, was still recorded in the book as present in the service. We mentioned these points to the registered manager to address.

We saw one person was prescribed medicine when required [PRN] to help relieve their anxieties and the protocol had been written by health professionals. We saw the required length of time between the maximum two PRN doses per 24 hours was not explicit. There was also no PRN protocol for pain relief medicine for the same person. The registered manager told us they would check this out with the health professionals involved in the person's care and treatment and make the instructions clear.

There was a controlled drugs cupboard for those medicines that required tighter security and a fridge for those that required cold storage. The medicines were delivered each week in a monitored dosage system by a local pharmacy and the deputy manager had responsibility for medicines management. There were information leaflets about the different medicines each person who used the service was prescribed. All staff had completed medication training, although only senior care support workers administered medicines to people.

We found there were sufficient staff on duty to support the current needs of people who used the service. At present there was one person who lived in Dales House, one person who attended for day care three times a week and several people who used the respite service on an intermittent basis. The staff rotas indicated there was one senior care support worker and two care support workers during the day; sufficient staff were employed at night. The registered manager or deputy manager worked each day during the week to provide management cover. There was an on-call system to make sure staff had cover out of usual working

Requires Improvement

Is the service safe?

hours for any emergencies. The registered manager told us the numbers of staff were flexible, for example, on the days of the inspection, one person attended for day care and a member of staff was identified to provide the person with one to one support. They also said when more people were admitted, staffing numbers would be adjusted. A member of staff said, "The staffing numbers depends on the service users we have."

The registered provider had safeguarding and whistle blowing policies and procedures. There was also local authority guidance on safeguarding risk analysis to aid the referral process of any concerns. All staff had completed safeguarding training; in discussions, staff were clear about the different types of abuse and the signs and symptoms that may alert them to concerns. Staff knew what to do should they witness abuse or if issues were disclosed to them by people who used the service, other staff or visitors. There was information on the staff notice board regarding the telephone numbers of the local safeguarding team and out of hours emergency duty team. Staff had access to safeguarding referral forms. The registered manager told us they were familiar with the local authority risk matrix tool and would telephone the local safeguarding team for advice if required.

We saw risk assessments were completed for areas such as moving and handling, eating and drinking, accessing the kitchen, car travel and accessing community facilities, using the shower and wheelchairs and handling the animals. The assessments provided staff with information about the risk and what steps to take to minimise it. The moving and handling information gave staff directions in how to support the person in order to maintain their safety and wellbeing. We saw there were emergency contingency plans to deal with utility failure, any need to evacuate the building, severe weather and heat waves.

We found the service was very clean and tidy without losing its homely feel. Day and night care support staff completed domestic tasks and people who used the service had some involvement as part of their activities of daily living. There were cleaning schedules which included a system to ensure the bedroom used for respite care was deep cleaned each time it was used. The service had infection prevention and control [IPC] policies and procedures and staff were to complete IPC training. We saw the service had a range of personal and protective equipment for use when required such as gloves, aprons and hand sanitiser.

Good

Is the service effective?

Our findings

One person who used the service told us they enjoyed their respite stays. Their comments included, "The food is nice; they ask me what I want" and "They let me choose what I want to do."

The care file of the person who lived in the service indicated their health care needs were met. An initial assessment identified health care needs but the information was incorporated in different care plans. We spoke with the registered manager about this and they told us they would include health care needs into one health action plan. There was evidence people who used the service had access to health professionals such as GPs, hospital consultants, occupational therapists and specialist nurses. Staff described how health professionals from the community team that supports people with learning disabilities [CTLD] visited people and supported them with health issues. For example, staff described how one person required dental care and treatment and CTLD staff were managing this. A health professional told us, "Staff liaise with us, ask for help and take guidance" and "The care provision is very good and meets [name] needs well", "They change support to meet [name] needs; they supported [name] in hospital." We saw one person had a specific health need and was required to keep their legs elevated. The registered manager told us how they had trialled equipment, found it was suitable, and then had purchased it to meet the person's need. The same person had not, since admission, required any medication to calm their anxiety which was an improvement for them.

We found people's nutritional needs were met and the meals prepared were well presented. There was plenty of food in the service including a range of fresh fruit and vegetables. There were menus provided in pictorial format but these were not currently used. The registered manager told us that as there were so few people using the service at present, staff spoke to them each day and made whatever meal they wanted. There was information about likes and dislikes in people's care files and we saw staff recorded the food and drink they had each day. Staff told us they sometimes used a process of trial and error to find out if people liked specific foods. Staff were supporting one person to extend the range of foods they currently ate as this was limited to a small number of items. They were using cookery books to assist in this and had found that when the person assisted in baking certain items, they would eat them.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of DoLS criteria and knew how to submit an application to the local authority when required. The registered manager confirmed applications for DoLS had been submitted for two people who used the service and these were progressing with the local authority. We saw staff had received an awareness session about MCA and DoLS and the registered manager told us staff were booked on a more in depth training course in May 2015.

We saw staff worked within the Mental Capacity Act 2005 [MCA] code of practice. Records showed us assessments of capacity were completed, and when the assessment indicated the person did not have capacity, best interest meetings were held with relevant people in attendance to assist the decision making process on the person's behalf. We spoke with staff about how they ensured people who used the service gave consent prior to care and support. Staff said, "Some people give us verbal consent when we ask them and others give non-verbal consent" and "We judge a willingness to engage in tasks as implied consent." During observations of care practice and interactions we saw staff checked with people to gain consent prior to completing tasks and ensured people made choices such as where to sit and what to eat and drink.

The registered manager confirmed that no people who used the service had a 'do not attempt cardiopulmonary resuscitation' [DNACPR] in place. They said these decisions would only be made following MCA principles.

As the service was new, most of the staff had started at the same time and completed an induction together before people were admitted to Dales House for care and support. We saw the induction was two weeks long and consisted of training considered essential by the registered provider, service specific training and policies and procedures. The training record and certificates showed staff had completed the essential training which included, safeguarding, first aid, moving and handling, health and safety, fire safety, food hygiene and medicines management. There had also

Good

Is the service effective?

been other important training relevant to the needs of people who used the service. This included, person centred support, effective communication, personal development, use of signs and symbols, epilepsy management, care with dignity, basic challenging behaviour, autism awareness, bowel massage and supporting people when they had difficulty eating and drinking. One new member of staff had also completed end of life training and equality and diversity. The registered manager confirmed staff were expected to complete the new care certificate or equivalent.

Staff told us they received sufficient training to make them feel skilled and confident when supporting people who used the service. Comments included, "We had an intensive induction which included a lot of training." A health professional and three social workers commented positively on the skills of the staff team. Comments included, "I have seen advanced skills from the staff", "I am happy with the care and support" and "Communication is really good; they keep us informed and get in touch if there are any concerns."

Staff confirmed they had supervision meetings with their line manager and received appropriate support. They said, "We have a strong management structure", "We have supervision monthly or as and when; there is also informal supervision on a day to day basis with discussions with seniors" and "Seniors observe practice and the deputy works on the floor." Staff confirmed that communication between each other and with management worked well. There were handovers between the two shifts and records showed staff signed the handover sheet to indicate specific tasks had been completed. There were also communication books where staff recorded specific information to be discussed with each other and the registered manager.

We saw the design of the premises had been adjusted to meet the needs of people who used the service. There were ramps at the front and rear of the building to assist people who used wheelchairs. There was also a low, free-standing work surface in the kitchen for people to use when seated to participate in cooking, baking and preparing meals. Corridors were wide and there was a range of equipment to assist people with their moving and handling needs. This included: a passenger lift, grab rails, ceiling track hoists in the bedroom used for respite services and in one of the bathrooms, a wall mounted changing facility in a bathroom and a portable call bell system. There was sensory equipment in the sitting rooms and objects of reference on door handles to provide information to people who used the service, for example a remote control to indicate there was a television in the room. We saw pictorial signs combined with easy read text were also used on doors and cupboards as reminders for people. The garden area at the rear of the property had been designed so people who used the service could sit out in warmer weather. There was a patio area with tables and chairs, a small grassed area, a raised bed for planting flowers and vegetables and an area for small pets. These currently included six chickens, a rabbit and a guinea pig.

Good

Is the service caring?

Our findings

One person who used the service told us they liked the staff. They said, “The staff are all nice.” A relative told us they wanted to remain a big part of their family member’s life and said staff supported them with this. They said, “[Name] loves it here; it is so different from their previous service”, “It really is a home from home” and “I still feel part of the care.” They also told us there were no restrictions regarding when they could visit the service and often popped in to see the person when they passed by.

Written feedback to the service from a relative stated, "We do feel a genuine caring spirit from the carers at Dales House. It is the little things that are making such a difference to [name]. The staff involve him in washing the pots, vacuuming and tidying up and he's involved in every aspect of daily life."

Comments from visiting health and social care professionals included, “It’s been a very positive experience for them; I’m happy with the care and support”, “They try and support [name] to be independent”, “[Name] has really settled well and staff seem caring. I have also observed privacy and dignity respected”, “It’s a really good staff team”, “I have had positive feedback from parents” and “I have observed good interaction between the staff and service users.”

During the inspection we observed the positive ways in which staff interacted and engaged with people who used the service. The service had a key worker system which enabled staff to develop relationships with people who used the service. The registered manager told us they tried to match staff with people based on common interests. One page profiles had been produced describing people’s interests and these were also to be completed for staff to help the matching process. We saw staff involved people as much as possible in completing personal care plans, deciding on activities and planning and preparing meals. Staff described how they ensured people had the opportunity to be involved in other activities of daily living such as laundry and tidying their bedroom. They said, “There have been lots of changes for [name], more goals have been decided and we have increased our communication tools with picture board”, “[Name] likes to hoover, do his laundry and make his bed with help” and “We have got to know [name] now and how he communicates; he can make choices and there are subtle things that tell us what he wants to do and what he doesn’t want to do.”

The information from assessments and care plans described people’s preferences and likes and dislikes. In discussions with staff, it was clear they knew the needs well of the people they supported. They told us they had time to read care plans and to provide information to add to them and update them. Staff told us they enjoyed working at the service and some comments included, “It’s emotionally rewarding work”, “It doesn’t feel like work” and “It’s an awesome service and feels like we are changing lives.”

During the inspection we observed staff support a person who used the service in activities outdoors. We saw staff encouraged the person to participate in the activities, they completed them at the person’s own pace, they respected the person’s choice to move onto other items and they gave them space when they wanted to complete a task on their own. We saw the person smiling with staff and using non-verbal means to communicate their enjoyment.

We saw people’s privacy and dignity was respected. Staff described how this was particularly important for one person who used the service and we saw all staff had been made aware of specific issues. We observed staff spoke to people in a caring, respectful and professional way. Staff were clear about how core values were maintained. They said, “Everyone has their own bedroom and their own space; we knock on doors – it’s drummed into us” and “[Name] likes to have the bedroom door closed at night.” We saw there were privacy locks on the doors to bedrooms, toilets and bathrooms and lockable facilities in bedrooms for people to store personal items.

Staff confirmed they used the office to discuss private conversations on the telephone or in person. We observe reviews of people’s care were held in the dining room with the doors closed for privacy.

Staff described how they provided information to people using signs, symbols and items to help them make choices and we observed how this worked for one person in practice during the inspection. We observed staff provided explanations to people before tasks were carried out. We

Good

Is the service caring?

saw specific documents had been printed in easy read and laminated. These included menus, how to complain and a hand book which included the promises the registered provider made to people who used the service.

There was information about advocacy services although this had not been used yet as the people who used the service had relatives to support them. The registered manager told us how they had liaised with mental health services to advocate on one person's behalf regarding the need for a review of their guardianship order.

We saw confidentiality was maintained. Care files were held in a lockable cupboard and staff files secured in the registered manager's office. The computer was password protected for security.

Good

Is the service responsive?

Our findings

A person who used the service told us there were activities for them to participate in and they were able to access community facilities. They said, “I go out every day; I’m going swimming on Sunday” and “I like the chickens and feed the rabbit and guinea pig.”

Comments from visiting health and social care professionals included, “Staff have started a book which details the activities and places he has been to” and “They are very active and like to be involved in social activities; they get that here.”

We saw written feedback from one relative about a person who used the service which was very complimentary. They had written, "The change in [name] since he has been at Dales House has been incredible to say the least" and "The staff have all worked so hard in getting to know [name] and understanding their complex needs. The staff have never had the need to give him the drugs that were prescribed to help prevent so called challenging and difficult behaviour."

We saw assessments and care plans were person-centred and included information about people’s preferences and the way they wished to be cared for and supported. There were also assessments which had been completed by health and social care professionals and relevant information had been included in care plans. The care files contained person-centred documentation for staff to complete as they got to know the people they supported. These included, “What’s important to me”, “How best to support me”, “What’s working well” and “What makes me happy/angry/uncomfortable/sad/annoys me.” There was also a personal profile which included people’s preferences, important relationships and health issues. Health and social care professionals said, “The care is very person-centred” and “The service gives him security; they are prepared not to take information as set in stone and they look at different challenges for him.”

The care plans provided staff with information on how best to meet people’s needs. They included how many staff were required for specific tasks, what levels of independence they had and what equipment was needed to support the person to maintain their safety and wellbeing. The care plan for one person indicated they liked to control their own money and described how they managed this on a day to day basis. It also described what community facilities they accessed. Another care file we checked had explored how the person communicated their needs and what they liked to do. It included a list of their favourite activities, food and TV programmes, and what their routines were at each stage of the day.

There had been occasions when staff had contacted health and social care professionals for advice and guidance when one person’s needs had increased. A health professional had attended a meeting to discuss the person’s care plan with staff and to review approaches to see if these could be improved.

Staff recorded daily entries about how care and support was provided to people. They also completed monitoring charts such as food and fluid intake, bowel management, weight and visits from visiting health and social care professionals.

The daily entries provided information on the activities people had participated in the service and the community facilities they had accessed. We saw these included, baking, preparing meals, tidying their bedroom, helping with laundry, craft work, shopping, swimming, cycling, visits to pubs, parks and local landmarks, using sensory equipment and gardening. One person visited a transport museum by train. Staff told us, “[Name] likes to do something every day, like going to museums, shopping and eating out.” They described how they had supported the person to play pool in a pub and also how the person enjoyed vacuuming and wiping down the bath after use. The registered manager had sourced specific sensory materials to use with one person who used the service. This had been very effective in meeting the person’s needs and providing stimulating experiences for them. There were sensory lights in the sitting rooms which projected images on walls and ceilings and we observed these in use during the inspection.

The registered manager told us how they had made links with community groups to expand the range of facilities for people who used the service. For example, through the local Cerebral Palsy Society people were able to access swimming sessions at a hydrotherapy pool, day trips out and a holiday home in Bridlington that has been adapted for people with mobility needs. The registered provider was a member of the Maxi Fun club which enabled them to access reduced price tickets for local shows and the East Park Cycle Scheme so people could use adapted cycles. The registered provider was also a member of the Echoes

Good

Is the service responsive?

Foundation, which has enabled them to hire specific sensory equipment and access a hydrotherapy pool. People attended local discos and theatres and staff told us one person was visiting a farm later in the week.

We found people were supported to ensure a smooth transition into the service when this was completed in a planned way. The registered manager described how one person was currently visiting the service at intervals to meet other people who used the service and staff, and to choose their bedroom and furniture; overnight stays had been factored into the transition plan. During the first two weeks of another person's access to the service, staff had worked with health professionals each day to learn specific approaches and to tailor a plan of care to meet their needs. We saw on one occasion staff checked out information in an assessment with relatives and found the issue had been resolved and the person was no longer at risk. We saw staff had created information booklets in easy read format to accompany the person should they be admitted to hospital. This helped to provide medical and nursing staff with a description of their needs.

There was a complaints policy and procedure which included timescales for acknowledging the complaint, investigating it and responding to the complainant. How to complain was produced in easy read format and included in a handbook given to each person who used the service. A copy of this was laminated and displayed in the entrance. There was also a suggestions book for people to leave comments and express their views about the service. One person who used the service had written in the suggestions book that they liked a specific member of staff.

Good

Is the service well-led?

Our findings

One person who used the service told us they knew the manager's name. They were also able to express their views about the service. We observed how the registered manager interacted with people who used the service and saw this was completed in a very positive way.

During the inspection, staff gave us positive comments about how the service was managed. They said, "It really is a positive place to work", "There's a very good philosophy; nothing is ever too much trouble", "Staff have been handpicked for their specific skills and qualities", "There is job satisfaction, a happy team, very little conflict and the smallest turnover of staff I have ever known" and "Line managers are very experienced." Staff confirmed the registered provider visited the service each week and they had the opportunity to talk to them about any issues. Staff said, "They are approachable and chat to staff when they visit."

There was a quality monitoring system in place which consisted of questionnaires and checks, although this was still under development due to the new status of the service. There was a full range of documents to use when completing audits and checks of the service but these had not been used yet. The registered manager and staff confirmed some checks were completed, for example on care files, medicines, finances, cleanliness, and staff training. Records were maintained of health and safety checks of hot water outlets and fire alarm zones tests. However, full implementation would take a longer timespan to achieve a full quality monitoring cycle with audits and action plans to address shortfalls. We judged that people were supported by staff and management who listened to them and had improved their care and support where necessary.

A survey had been developed for people who used the service and two had been completed to date. We found the survey had questions which were complex and would be difficult for people who used the service to understand fully and complete with minimal assistance. We spoke with the registered manager about this and they confirmed these would be reviewed and developed in an easy read format.

The registered manager was aware of their role and responsibilities to keep agencies informed of incidents which affected the safety and welfare of people who used the service. We had received a notification of a possible medicines error. This was investigated and steps put in place to learn from the incident to prevent it from being repeated. We saw records had been maintained of accidents and also of incidents that related to one person's behaviours which had challenged the service. The registered manager told us they had spoken with staff following any incident when the person's behaviour had challenged staff and property. There were no debrief records to confirm analysis of incidents had taken place, what approaches had worked or not and what other steps, if any, staff could take to support the person during their distress. However, we saw minutes of a meeting that indicated support and guidance had been sought after an incident and the person's care plan discussed with a health professional.

We spoke with the registered manager about the culture, vision and values of the organisation. The registered manager told us of their personal and professional experiences and training (they are a qualified social worker and approved mental health professional) which had formed the basis for their management style. They said the service was based on the principle of 'the family' and people who used the service were involved in all aspects of daily living as much as possible. They said, "There should be no barriers or divides between staff and members [people who use the service]; it is their home and a privilege for us to work here" and "There has to be some structure but it has to be flexible so we can enable people and address power imbalance." The registered manager told us they had chosen members of staff carefully and had supervised them herself in the first few months. They described their management style as inclusive with an open door policy, "It's not about hierarchy; we all have roles and a job to do."

There was information which described the philosophy of the service in written word and using symbols. This included the promotion of an individual's right to family life and social inclusion, to encourage participation in family and social life and to focus on individual goals. Although the service was relatively new, we saw these had been achieved in practice.

We saw team meetings were held on a monthly basis to exchange information and to ensure staff were able to express their views and make suggestions about the running of the service. The registered manager told us staff

Good

Is the service well-led?

turnover was low and they helped to promote this by creating a positive atmosphere, being 'in touch' with staff and valuing their contribution. Staff were able to purchase meals for a nominal fee and they were able to receive discount at specific stores.

The registered manager discussed the model of service and 'client group' they intended to provide care and support to. They stated they had not intended to provide a service to people who had behaviours that would be challenging to other people who lived there. This was confirmed in registration documentation checked prior to the inspection. However, there had been a situation when one person's needs had changed during their stay at the service and it had not been possible to continue to meet their needs. This had resulted in the person leaving the service. The registered manager said they wanted to work closely in partnership with commissioners and professionals who completed assessments of people's needs to ensure the situation did not reoccur. The registered manager sat on a local Partnership Board to assist in reviewing the local LD strategy.

The registered manager told us they were signed up to the Foundation for People with learning Disabilities and was able to access information via their website on current research and policy guidance to improve practice. We saw the registered manager obtained information about the local services available to people with learning disabilities [LD] prior to the opening of Dales House. This involved visiting other services, checking out equipment and consulting with the local authority health and safety officers. They also liaised with specific schools to look at transition arrangements when young adults moved from childcare services to adults services.