Solor Care (South West) Ltd

Wey House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 February 2016 and was unannounced.

At the last inspection on 12 February 2015 we found improvements were required. There was inconsistency and lack of clarity about some aspects of people's care records and social and leisure activities were limited. At this inspection we followed this up and found improvements had been made. We found a significant improvement in the consistency and accuracy of people's health monitoring records and people were enjoying greater staff engagement and more recreational activities.

Wey House is registered as a nursing home for up to 37 people with complex neurological conditions, acquired brain injuries and/or other physical disabilities. People who live at Wey House have complex nursing and other support needs and many of them are unable to communicate verbally. At the time of the inspection there were 20 people living at Wey House. A major refurbishment to improve the environment had recently been completed. There were now 31 modernised bedrooms available. The provider has applied to change the home's registration accordingly, to accommodate a maximum of 31 people. The home is also equipped with assisted bathrooms, a hydrotherapy pool and other specialised rehabilitation facilities to support people's complex mobility needs.

The previous manager of the home had left a couple of months earlier. The two new home managers had applied to the Care Quality Commission to become the registered manager for the service, on a job share basis. Their application was still in progress at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived in the home, their relatives, staff and external healthcare professionals all said the home's new managers were very open, accessible and responsive. One relative said "The managers are very good and they definitely care about the residents". A senior healthcare practitioner said "[Manager's name] has got the place by the scruff of the neck and is driving up improvements". All of the staff we met were highly motivated and spoke positively about the service. They said everyone worked really well together as a supportive and dedicated team.

People's needs were fully assessed, prior to moving to the home, and regularly thereafter to ensure people's changing care needs were met. There were always at least two qualified nurses on the day shifts to ensure people's complex clinical needs were monitored and met. A community nurse specialist told us "There have been no recent concerns or safeguarding issues".

People and their relatives told us the management and staff were very caring and always treated them with respect. One person who lived in the home said "I think it's a lovely home. The staff are all genuine, friendly and kind people". We observed numerous examples where staff demonstrated a caring and compassionate

approach toward the people they were supporting. There were also examples of valuing and involving people in the running of the home. A new member of care staff informed us that one of the people who lived in the home was on their interview panel.

People had a range of specialised equipment available to them and regular testing took place to ensure equipment was safe for people to use. However, some checks were not consistently recorded. The managers undertook to address this straight away.

Staff told us there were always sufficient staff numbers to keep people safe and to meet their needs. The number of agency staff hours had reduced by almost half since the recruitment of new permanent care staff. Current nurse vacancies were covered by block bookings of regular agency nurses to ensure consistency, pending recruitment of permanent nursing staff. Staff said everyone worked well together as a really supportive team. People were supported by in-house nurses, care staff, physiotherapists and occupational therapists, and had access to a range of external healthcare professionals when specialist advice was needed.

Each person had a designated key worker and a key working team responsible for ensuring their individual needs and preferences were identified and acted upon. We observed staff always responded promptly to call bells or whenever people needed support or displayed any sign of anxiety or distress.

We observed the lunchtime meals and saw staff supported people appropriately and in an unhurried way. Staff were very attentive, friendly and quick to respond whenever a person needed assistance. People had a choice of meals and drinks at lunchtime, breakfast and supper. The chef ensured special dietary needs were met, such as soft and pureed meals for people with swallowing difficulties.

People received their medicines safely from registered nurses and people were protected from the risk of infection. The home was well maintained, clean and tidy throughout.

The provider had a quality assurance system to check the service continued to meet people's needs effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of suitably trained staff to keep people safe and meet their needs.

People were protected from abuse and avoidable harm.

People received their medicines safely from registered nurses and people were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care from staff who were trained to meet their individual needs. They had access to external healthcare professionals when more specialised advice was needed.

The provider acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People had their nutritional needs assessed and received a diet in line with their individual needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

People were supported by committed staff who were compassionate and patient.

People were supported to maintain ongoing relationships with their close relatives.

Is the service responsive?

Good

The service was responsive.

People enjoyed an increased variety and amount of social and leisure activities. Further improvements were planned, particularly for people who were unable to independently participate in activities.

People received care and support that met their needs and took account of their wishes and preferences.

People, relatives and staff felt able to express their opinions and management responded positively to any feedback or complaints.

Is the service well-led?

Good

The service was well led.

People were supported by a highly motivated team of staff and managers.

The management team was open, accessible and responsive. There was a clear staffing structure and a good staff support network.

There were systems in place to monitor the quality of the service and to drive further improvements.

Wey House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 February 2016 and was unannounced. It was carried out by an inspector and a specialist nurse advisor.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The service was last inspected on 12 February 2015. At that time, we found improvements were required due to inconsistency and lack of clarity in some care records and limited social and leisure activities for people to enjoy.

During this inspection we spoke with five people who lived in the home, two visiting health professionals and the two home managers. We also spoke with nine other members of staff, including nurses, support workers, occupational therapy and kitchen staff. To help us understand the experience of people who could not talk with us, we also observed staff practices and their interactions with the people they were supporting. Following the inspection we telephoned the relatives of two of the people who were unable to communicate with us. We also called two other senior health professionals who knew the service well.

We looked at records which related to people's individual care and to the running of the home. These included seven care plans, including food and fluid intake charts, two staff recruitment files, four medication records and other quality assurance records including staff training, complaints and incident files.

Good

Is the service safe?

Our findings

Most of the people who lived in the home had little or no verbal communication skills. This meant we were only able to have meaningful conversations with a small number of people. To help us gain more information about people's experiences of the service we also spoke with some relatives of people unable to communicate with us. People and their relatives told us they felt safe. One person who lived in the home said "Yes, I'm well treated. I get on with all the staff". Another person said "I've never seen staff treat anyone badly". A relative said "I visit the home regularly. I've never seen anything like abuse or neglect".

People were more vulnerable to abuse due to their complex mental and physical disabilities. The service protected people from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had no concerns about any of their colleagues' practices but would not hesitate to report something, if they had any worries. Staff were confident the provider would deal with any concerns to ensure people were protected.

The risks of abuse to people were also reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure staff were safe to work with vulnerable adults. New staff told us they were not allowed to start work until satisfactory checks and employment references had been obtained.

Records showed the provider met their statutory requirements to inform the local authority safeguarding team and the Care Quality Commission of notifiable incidents. A community nurse specialist told us "There have been no recent concerns or safeguarding issues". Staff completed an incident report whenever an incident occurred. The incident was investigated and plans put in place to minimise the risk of recurrence. Incident reports were signed off by the home manager together with any learning from the incident. Incident reporting was included in the provider's quality monitoring system. It was reviewed routinely to see if any improvements to practice could be made and any learning was cascaded to the provider's homes.

Care plans included risk assessments outlining measures to ensure people received care safely. The assessments identified people's individual equipment and staffing support needs. They covered areas including: mobility and pressure sore risk, falls, use of bedrails, malnutrition screening, swallowing and choking, personal hygiene, and medication. Staff were aware of those people at risk and kept them under supervision.

We observed people had a range of equipment available to them to meet their individual needs. This included hoists, assisted bathing equipment, electric wheelchairs, pressure relieving mattresses and sleep system equipment. People at risk of falls were provided with suitable mobility aids. We observed staff repositioning people using hoists and slings. People were moved safely and their dignity was maintained.

The service had a planned equipment maintenance programme and regular testing to ensure equipment was safe for people to use. However, some important checks were not being consistently recorded. Daily

resuscitation equipment checks were incomplete and daily pressure relieving mattress settings were not recorded. One of the nurses told us the resuscitation equipment was in continual use and therefore was being checked regularly, but accepted this was not being recorded. Similarly, although we did not identify concerns regarding pressure areas, the lack of mattress setting records meant there was a potential risk. Incorrect settings could result in pressure sores developing. We discussed these concerns with the home managers who agreed to implement daily recording of resuscitation equipment and pressure mattress settings with immediate effect. Documentation of weekly suction and nebuliser checks also needed auditing to ensure consistent recording.

Staff knew what to do in emergency situations. For example, there were protocols for responding when people experienced epileptic seizures. There were service continuity plans in the event of an emergency situation, such as a fire or utilities failures. Specialist contractors were employed to carry out fire, gas, and electrical safety checks to ensure the environment was safe. Regular health and safety checks were carried out by the managers and the provider carried out an annual health and safety risk assessment of the home. There was a comprehensive range of health and safety policies and procedures for staff to follow.

There were enough staff to meet people's complex needs and to keep them safe. There were usually 12 care support staff and two registered nurses in the morning; 11 care staff and two nurses in the afternoon; and one nurse and four care staff (plus one twilight, until 12 midnight) at night. Staff confirmed there was always sufficient staff to keep people safe and to meet their needs. Several people with high dependency needs received one to one staff support and staff said extra staff were available when additional assistance was needed.

The provider had an ongoing recruitment programme and had recently been successful in recruiting a number of new care support staff. Interviews had also been arranged for four nursing vacancies. Staff overtime and/or regular agency staff were used to cover holidays and other absences. We were told the number of agency hours had reduced by almost half since the recruitment of new care staff. The managers said they were currently covering the nurse vacancies through block bookings of regular agency nurses to ensure consistency. They also worked some of the shifts themselves which helped them to keep their 'hand-in'. One of the managers is a registered nurse and the other a health and social care assessor.

People received their medicines safely from staff who had been trained and assessed as competent to administer medicines. We observed a medicines round and saw people were given their medicines in a safe, considerate and respectful way. The nurse checked to ensure the correct medicines were given at the right times. Medicine administration records (MAR) were accurate and up to date. The service reported only two medicine errors in the last 12 months. Many providers use a red 'do not disturb' tabard to reduce disturbances and errors, however, the nurse was not wearing a tabard while administering people's medicines. We were informed the lead nurse carried out a daily audit of MAR sheets and all medicines were audited monthly. These checks helped to ensure the correct medicines were administered to the right people at the right time.

The local GP carried out regular medication reviews to ensure people's prescriptions were up to date and appropriate. Medicines were kept safe and there were suitable arrangements for looking after medicines which needed additional security or required refrigeration. The provider had an appropriate medicines policy and procedures.

People were protected from the risk of infection. The home was well maintained and appeared clean and tidy throughout. We observed regular cleaning of the premises by housekeeping staff during our inspection. All but one of the 31 bedrooms had been completely refurbished since our last inspection. Rooms had been

modernised and redecorated to suit the needs and tastes of the people who lived in the home.

Hoists, wheelchairs, equipment, toilets, bathrooms and people's rooms were clean and tidy. Staff wore appropriate disposable personal protective equipment (PPE) when providing personal care and when preparing or handling food. There were sufficient supplies of personal PPE for staff to use. There were discreet symbols placed on relevant bedroom doors to alert staff and visitors where there was an increased risk of infection. There were notices around the home advising staff on how to maintain a safe level of hand hygiene.

Good

Is the service effective?

Our findings

At our last inspection we found improvements were needed due to inconsistencies and a lack of clarity in recording people's care. At this inspection we found improvements had been made. People's health monitoring records were now more consistent, accurate and up to date. For example, the daily care notes were more thorough and the daily fluid intake charts were consistently totalled. An external community nurse specialist said "There has been a huge improvement in care planning and documentation".

People and their relatives told us the service was effective in meeting people's needs. One person who lived in the home said "The staff are friendly, kind and very professional. There is the occasional blip with agency staff but [manager's name] is very good and sorts things out". A relative said "They have an excellent team of friendly staff who work really well together".

People's needs were fully assessed prior to moving to the home, and regularly thereafter, to ensure people's changing care needs were understood and met. Appropriate equipment was in place as needed. For example, people at risk of pressure damage to their skin had specialist pressure relieving equipment. The home was also equipped with assisted bathrooms, a hydrotherapy pool and other specialised rehabilitation facilities to support people with complex mobility needs.

People had complex physical and mental health conditions. A number of people were fully dependent on the staff for their needs. They required one to one staff support to assist them with eating and drinking (due to dysphagia i.e. difficulty swallowing), needed continence support and regular repositioning to prevent pressure sores developing. Daily care records showed these requirements were being carried out in line with people's agreed care plans. There were always at least two qualified nurses on each day shift to ensure people's clinical needs were monitored and met.

Some people were less dependent in physical terms but had acquired brain injuries which sometimes affected the way they behaved. For example, they could sometimes display physical or vocal signs of distress when they became agitated. We observed staff responded in a timely manner whenever people displayed signs of anxiety or distress. Staff were trained in non-physical interventions, such as distraction and calming techniques, as well as the safe use of restraint as a last resort to keep people safe.

Staff were knowledgeable about each person's needs and preferences and provided support in line with people's agreed plans of care. They received training to ensure they had the necessary knowledge and skills to provide effective care and support in line with current best practices. This included generic topics, such as: safeguarding, first aid, infection control, administration of medicines, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Person specific training was also provided to meet people's individual needs, including: epilepsy and individual communication strategies for people with no speech. Training records showed staff were up to date with their mandatory e-learning and training. The provider also supported staff with their continuing training and development, including vocational qualifications in health and social care.

New staff told us they had completed a comprehensive four week induction programme. They then shadowed experienced staff until they got to know people's individual support needs. The competency, knowledge and skills of new staff were assessed at monthly probation meetings to ensure they were able to care for people effectively. New staff had to complete the Care Certificate programme. All staff received regular one to one supervision sessions with annual performance and development appraisals. This ensured regular performance reviews took place and there was an opportunity to discuss any further training or development.

Staff told us everyone worked well together as a really supportive team and this helped them to ensure people received effective care and support. They discussed people's individual care and support needs regularly at shift hand-overs, staff supervision sessions and monthly team meetings. They said they could rely on the managers and the shift leaders for advice or assistance whenever needed. A new member of staff said "The shift leaders are really good and are always around if you have any questions. Both the managers are amazing and they always have time for you. There's a really good support network and I've never felt out of my depth".

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We observed when people lacked the mental capacity to make certain decisions the service followed a best interest decision making process. Staff had also received training and had an understanding of the requirements of the MCA and the DoLS.

Nine DoLS authorisations had already been granted and six applications were still pending a decision. This showed the service had followed the requirements in the DoLS. We saw there were associated risk assessments and best interest decisions documented in people's care plans. We were told restrictive practices were regularly reviewed with a view to reducing the number and impact of any restrictions on people's freedom, rights and choices.

People were supported to access a range of external healthcare professionals to help maintain their health and wellbeing. This included healthcare practitioners from the local GP practice, speech and language therapists, dieticians, tissue viability nurses and other specialist nurses. The service employed its own in-house physiotherapists and occupational therapists. We saw records of multi-disciplinary assessments within people's care plans.

People were supported to have sufficient to eat and drink and to have a balanced diet. People's nutritional needs were assessed and staff were knowledgeable about each person's dietary needs and preferences. Some people were prescribed food supplements and others required food and drink at a specific consistency to help them swallow and avoid choking. People who were unable to swallow received their nutritional needs through a percutaneous endoscopic gastrostomy (PEG) feed tube inserted into their

stomach. The registered nurses were trained in PEG administration by an external specialist nurse.

We spoke with a community dietician and a specialist nutritional nurse who were visiting the home for their routine quarterly review meeting. Both commented on the improvement in managing PEG feeding and the excellent communications they had with the home's clinical lead (one of the home's managers). They said over recent months they had observed improved food intake records, bowel movement charts and weight records.

The service had a rolling six weekly lunch menu with two different meal choices each day. People were happy with the meals but some of the care staff thought there could be more variety, particularly for people on soft diets. The chef said they were happy to provide alternatives if people did not want the menu choices. She prepared meals with ingredients that were suitable for both regular and soft diets, such as her own pastry formula that was easy to mash up.

People also had a choice of breakfasts and suppers. Mid-morning and afternoon snacks had recently been introduced, including home-made scones, fresh fruit, trifles, yogurts and other soft snacks. People could have their choice of drinks including fruit juice, tea, coffee and milk shakes. The chef said they regularly spoke with people after each meal to check they enjoyed their food and whether they were happy with the choices. They also talked with relatives of people who were unable to speak to ascertain people's food preferences. The chef ensured people's special dietary needs were met. Soft and pureed meals were prepared for people who had swallowing difficulties. The portion sizes and calorie intake was controlled for people who needed to lose or gain weight for health reasons.

Most of the people in the home were assessed as at risk of malnutrition or dehydration due to their complex health conditions. People's daily food and fluid intake was recorded and the nurses monitored their daily intake. If people had less than the required daily amounts they were encouraged to have extra food or fluids the following day.

We observed the lunchtime meals and saw staff supporting people appropriately and in an unhurried way. Staff were very attentive, friendly and quick to respond whenever a person needed assistance. Some people received one to one staff support with eating their meals, others were assisted by staff cutting up their food into small portions and others received soft or pureed meals. A number of people were able to eat their meals unassisted with the aid of plate guards and specially designed cutlery. We observed staff periodically moved the plates around to assist people to use the plate guards more effectively. Some people preferred to have their meals in their own rooms and this was respected. At one person's request, sandwiches were provided in their room instead of the set menu choices.

Good

Is the service caring?

Our findings

People and their relatives told us the management and staff were very caring and always treated them with respect. One person who lived in the home said "I think it's a lovely home. The staff are all genuine, friendly and kind people". Another person said "I love [staff member's name] and all the other staff". A relative said "We are very pleased with the way staff greet and engage with us".

Staff displayed a friendly, kind and caring approach toward the people in the home. We heard staff speaking with people in a polite and caring manner. Staff knelt down to be on the same level as people when they spoke with them. We heard staff consulting people about their daily routines and preferences and no one was made to do anything they did not want to. People were encouraged to make their own decisions, as far as they were able to. We observed staff offered people options to choose from and then acted on the person's wishes.

We observed numerous examples where staff demonstrated a caring and compassionate approach. For example, at lunchtime, staff took sufficient time to assist people without hurrying them. We observed a person with complex disabilities receiving staff support with their meal. The member of staff checked to ensure the food was not too hot before patiently offering small helpings to the person. At one point the person started to cough. The member of staff was clearly very concerned to ensure the person was OK and a nurse also came over straight away to check the person was not choking. After a short break, the person was fine and able to resume their meal.

We observed another member of staff patiently asking a person with physical and mental health needs, and very limited speech, what they would like to drink. The person was completely absorbed with completing their colouring book and did not respond. The member of staff then made direct eye contact to gain the person's attention and asked politely again about their drink choice. Later on, the person accidentally dropped their colouring pen on the floor. The member of staff noticed this, picked it up and handed it back to the person much to their obvious delight.

One person who was nearing the end of life was not very responsive and was unable to speak. We observed staff moving them in their wheelchair to different areas of the home so they could "enjoy a change of scenery". We were told the beauty therapist was visiting the person later to file their nails to help prevent them from scratching themselves.

Everyone looked well cared for, they were appropriately dressed in clean clothing, their hair looked clean and tidy and their fingernails were short and clean.

Staff demonstrated a good knowledge of each person's individual needs and preferences. Each person had an assigned key worker and a dedicated key working team. The keyworker was a member of staff they had a good relationship with. The key worker had particular responsibility for ensuring the person's current needs and preferences were identified and acted on by all staff.

Staff were trained to communicate effectively in ways people could understand. We observed staff were patient and persevered, without rushing people, to ensure people's wishes were understood and acted on. Many of the people had difficulty expressing their choices through speech and could not relate well to pictures or symbols due to their condition. Each person had an assessment by a speech and language therapist who advised and supported staff with relevant communication techniques. Where people had limited communication skills the views of close relatives, or other people who knew them well, were taken into consideration. Where appropriate, people were supported to access independent external advice and support if they needed help with making important decisions.

People with the capacity to do so were able to choose where to spend their time. They could spend time in the company of others in the communal areas or choose the privacy of their own rooms, as they pleased.

Staff respected people's privacy and dignity. Personal care was only provided in the privacy of people's bedrooms or in the home's private bathrooms. Staff ensured doors were closed and curtains or blinds drawn when personal care was in progress. If someone knocked on the door while personal care was in progress, staff always checked who it was and covered the person before opening the door. Staff respected people's privacy by knocking on people's doors and waiting until they were invited in. Throughout the inspection, we observed staff assisted people in a discrete and respectful manner.

Staff spoke warmly and respectfully about the people they supported. They were careful not to make any comments about people of a personal or confidential nature in front of others. Staff respected people's confidentiality and made sure care plans were not left unattended for other people to read.

People were supported to maintain relationships with their families and friends. Relatives said they could visit at times convenient to them. There were no set visiting times or unreasonable restrictions. Relatives told us they were made very welcome when they visited and were encouraged to be involved in their relative's care planning. Staff also supported people to visit their families, where this was agreeable to all concerned. This helped people to maintain relationships with the people who cared most about them.

Information about people's end of life preferences and any spiritual or religious beliefs was included in their care plans. The provider supported people to practice their spiritual and religious beliefs where this was important to them. For example, some people were supported to attend local church services. Local clergy visited the home to provide pastoral care for people who requested it. Church volunteers also visited the home and provided additional social contact and support with activities, such as reading to people.

Good

Is the service responsive?

Our findings

At the last inspection we found social and leisure activities for people were limited and improvements were required. At this inspection we followed this up and found improvements had been made. People were enjoying greater staff engagement and more social and recreational activities were available to them. One person said "I'm very happy here. It's a very nice home and when I go out into the gardens it's lovely and quiet". Another person said "It's brilliant. I'm much happier here". A relative told us "They are definitely meeting [their relative's] needs and they always have options to choose from".

However, another relative said "Things have improved but my constant bug-bear is lack of mental stimulation, I think they could do more". The home managers said a lot of improvements had already been made and further activities were planned to interest and stimulate those people who were unable to participate in activities independently.

People's recreational activities varied according to their individual needs and interests. Where people had difficulty communicating their preferences, relatives and others involved with their care were involved in the planning of their activities. For example, a community nurse specialist told us about a person who had reduced mental capacity and very complex behavioural needs. Two of the home's care staff took the person on holiday, following a best interest meeting, and she said the person had a "fantastic experience".

We observed a weekly activities planner pinned to the home's notice board. This detailed the various morning and afternoon activities organised for each day of the week. We were told the scheduled activities were reviewed and changed on a monthly basis. Activities included visits to a wildlife project, a day centre and an evening disco. There were also in-house activities such as group readings, music therapy, pet therapy and beauty therapy. Ad-hoc activities, including trips out, sessions in the home's hydrotherapy pool, physiotherapy treatments and cooking sessions were also available each week day. There was a white board providing details of any ad-hoc activities provided on the day.

Each person had a comprehensive care and support plan based on their assessed needs. Care plans described people's individual care and support needs, decision making capabilities and things they enjoyed or disliked. People's complex needs were assessed prior to moving to the home to ensure the service could provide the necessary care and support. Care plans were then regularly reviewed and updated to reflect changes in the person's needs or preferences. Each person had a designated key worker and a key working team responsible for ensuring their individual needs and preferences were identified and acted upon. The managers audited the care plans to ensure they were appropriate to each individual's current needs and preferences.

Care plans provided clear guidance for staff on how to support people's individual needs. People were supported in line with their care plans by staff who had a good knowledge and understanding of their needs and preferences. Several people received one to one staff support due to their high dependency needs. We observed staff also responded promptly to call bells or whenever people needed support or displayed any sign of anxiety or distress.

People contributed to the assessment and planning of their care, as far as they were able to. People's views were sought and it was recorded where people were unable to make certain decisions about their care. In these circumstances, staff consulted with close relatives and other professionals involved with people's care. Care records showed people had regular assessments by a range of health and social care professionals. Care plans included people's daily routines, communication plans, decision making profiles, mental capacity assessments and any best interest decisions made on their behalf.

People were able to make certain choices about the staff who supported them, such as who they preferred as their keyworker. Staff members of the same gender were also available to assist people with personal care, if this was their preference.

People's rooms were furnished and decorated to suit each person's individual tastes and choices. Each room was personalised with the person's own belongings and decorated in the colour scheme of their choice. For example, one person had an electronic organ in their room and was keen to play us a tune when we met with them. People could choose to have the company of others in the communal areas of the home or to spend time alone in their rooms, if they wanted some privacy.

People, relatives and staff told us the managers were very accessible, approachable and responsive. They said they could go to either of the managers and any issues or complaints would be resolved appropriately and quickly. One relative said "We don't have any concerns. The managers keep us updated and are very responsive. They are very approachable and I would have no hesitation speaking to either of them if I had a concern".

The provider had a policy and procedure for managing complaints about the service. It gave people information about how to make a complaint and the timescales for responding to people's concerns. There had been one formal complaint in the last 12 months. This had been investigated and responded to appropriately and within the stated timescales.

Good

Is the service well-led?

Our findings

People who lived in the home, their relatives, staff and external healthcare professionals all said the home's managers were very open, accessible and responsive. One relative said "The managers are very good and they definitely care about the residents". Another person's relative said "They seem very good, but I'm dismayed at the number of management changes". A senior healthcare practitioner said "[Manager's name] has got the place by the scruff of the neck and is driving up improvements, but they need to keep their foot on the accelerator".

The previous manager of the home had left a couple of months earlier. The two new home managers had applied to the Care Quality Commission to become the registered manager for the service, on a job share basis. Their applications were in progress at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Together with the provider, they have legal responsibility for meeting the statutory regulations governing how the service is run.

During our inspection we had discussions with both of the new home managers and one of the provider's Operations Managers, who visited the home during the inspection. The Operations Manager told us "Above all else the service philosophy is to provide person centred quality care and each home is encouraged to develop its own personalised service ethos".

Staff received training in current best practices to ensure they were able to understand and deliver the service philosophy. There was a comprehensive induction programme for new staff and continuing training and development for established staff. The service philosophy was reinforced at monthly staff meetings, shift handovers and one to one staff supervision and appraisal sessions. The provider had policies, procedures and operational practices to support its philosophy of care.

Decisions about people's care and support were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of reporting and accountability; from care staff to the home's managers, to the provider's senior management. Staff were highly motivated and spoke positively about the service. They said everyone worked really well together as a supportive and dedicated team. One of the nurses said "The managers are very supportive, and always around. There is good support and good teamwork". A care support worker said "You can go to either one of them, their door is always open. They are both in most days of the week and they alternate at weekends".

The provider had a quality assurance system to check they continued to meet people's needs effectively. These checks covered all key aspects of the service to ensure high standards were maintained and any areas for improvement were identified. The checks included a manager's weekly service report with a grading tool to alert senior management to any serious issues. The weekly service reports were monitored by the Operations Managers and the information used to generate a monthly service risk score card and service risk reduction report with an action plan. Action plans were regularly reviewed by the home managers and the Operations Managers. In addition, there were unannounced site visits by the provider's Operations Manager, Chief Operating Officer and Chief Executive Officer. The provider's central Quality Compliance

Team carried out stringent annual audits as part of each service's annual service review. These systems ensured effective implementation of actions to address shortfalls and improve quality standards for people who use the service.

People and their relatives were encouraged to give their views on the service through routine day to day conversations, care plan reviews and an annual satisfaction survey. Relatives said they were always kept informed about any issues and they could contact staff and management at any time if they wanted to discuss anything. A new member of care staff informed us that one of the people who lived in the home was on their interview panel. When they were offered the job, it was the person who lived in the home who came out and told them they had been successful. This was an excellent example of valuing and involving people in the running of the home.

The provider participated in forums for exchanging information and ideas and fostering best practice. The provider was a member of the Registered Care Providers Association (RCPA) and was accredited with the British Institute for Learning Disabilities and Investors in People. Management and staff attended service related training events and conferences and accessed relevant online resources for further information and advice. This included Skills for Care, National Institute for Health and Care Excellence (NICE), Care England, the Huntington's Disease Association, Parkinson's Society, St John's Ambulance Service, and the Care Quality Commission's website. The provider regularly reviewed and updated its policies and procedures in line with current legislation and best practice. Monthly management team and staff meetings were held to discuss and disseminate information and new ideas, and to keep staff informed about developments.

The service worked in partnership with other agencies. They had good links with local health and social care professionals. More specialist support and advice was also sought from relevant professionals when needed. This helped to ensure people's complex health and wellbeing needs were met.

People were supported to engage in the community, to the extent they were able to. Staff supported people to go out into the community, to go shopping, visit places of interest, have meals and drinks, and visit relatives or friends. The service had strong links with a local church which provided volunteers to read to people and a musician who visited the home each week.