Norwood

Norwood - 159a Station Road

Inspection report

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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 12 and 17 August 2016 and was unannounced. The service met all of the regulations we inspected against at our last inspection in October 2013.

'Norwood – 159a Station Road' is a care home for up to eight adults. The service is spacious and provides accommodation on the ground and first floor. It specialises in providing services to people who have a learning disability or who are on the autistic spectrum. Autism is a lifelong condition that affects how a person communicates with and relates to other people, and how they experience the world around them.

There was a registered manager in post at the service. A registered manager is a person who has registered with the 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 outstanding feature of the service was that staff were exceptional at communicating effectively with people on an individual basis, and used this as a basis for valuing people and developing their autonomy and independence. Staff had received a lot of support to develop skills in these areas, and there was on-going investment at embedding these processes. This had a positive impact on people's behaviours and the involvement in their care. This helped to demonstrate a very caring service, which matched the highly positive feedback we received from people's relatives.

We found there to be a positive, inclusive and empowering culture at the service. The registered manager led by example, providing good support to staff and ensuring that appropriate values were upheld towards people using the service.

Attention was paid to people's safety but in a way that minimised restrictions on their freedoms. For example, whilst many people had positive behaviour support plans in place to help minimise use of any behaviours that challenged the service, there was little reliance on as-needed medicines as part of those plans. Instead, there was an emphasis on recognising and understanding people's communications, and providing a service that responded to their experiences. There were also effective safeguarding procedures in place.

People were treated with respect and their privacy and dignity was promoted at all times. Attention was paid to keeping the service clean. The service had a number of long-standing staff who knew people well, which helped to enable positive and trusting relationships to be developed with people using the service. There were enough staff working at all times, although there was some reliance on agency staff to address staffing vacancies.

People had opportunities to take part in a variety of activities both in the premises and the community. Good effort was made to match and develop activities that matched people's abilities and preferences.

People received good support in respect of their individual healthcare and nutritional needs. The service liaised promptly if there were any concerns about anyone's health, and followed community healthcare professional advice well.

Whilst the provider's mandatory training was not consistently completed by some staff, staff received a range of additional training that helped to ensure that people using the service received effective and individualised care.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety. However, further work was needed with ensuring that the principles of the Mental Capacity Act 2005 were consistently applied for everyone using the service.

The service listened to feedback and acted on it. There was a formal complaints process in place but it had not been needed recently.

The service audited quality to help ensure good care was provided. Changes were made to the service as a result of any concerns being identified.

However, we found one breach of regulations. Temperature control systems for the safe storage of medicines and refrigerated food were not effective at identifying and addressing risks. This was because records showed that temperatures were consistently too high and that there had not been sufficient action to address risks arising from this. You can see what action we have told the provider to take at the back of the full version of this report.

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's medicines and refrigerated food were not always stored at a safe temperature, and control systems for this were not consistently effective at identifying and addressing risks.

Attention was paid to assessing risks to people on an individual basis and ensuring that action was taken where needed. People were safely supported to take prescribed medicines.

The service was suitably staffed, with an experienced team that had been appropriately recruited. There were effective safeguarding procedures in place, and the attention was paid to keeping the service clean.

Is the service effective?

Good

The service was effective. People received good support in respect of their individual healthcare and nutritional needs. The service liaised promptly if there were any concerns about anyone's health, and followed community healthcare professional advice well.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety. However, further work was needed with ensuring that the principles of the Mental Capacity Act 2005 were consistently applied for everyone using the service.

Whilst the provider's mandatory training was not consistently completed by some staff, staff received a range of additional training that helped to ensure that people using the service received effective and individualised care.

Is the service caring?

Outstanding

The service was very caring. There were creative and extensive ways to make sure that people had accessible, tailored and inclusive methods of communication. This formed the basis for valuing people and developing their autonomy and independence. Staff had received a lot of support to develop skills in these areas, and there was ongoing investment at

embedding these processes.

People were treated with respect and their privacy and dignity was promoted at all times. Positive and trusting relationships were developed with people using the service.

Is the service responsive?

Good

The service was responsive. People received personalised care that was responsive to their needs and preferences. People's individual support was kept under review and updated based on what people communicated. The service also listened to relatives' feedback and there was a formal complaints process in place.

People had opportunities to take part in a variety of activities of their choosing both in the premises and the community. Good effort was made to match and develop activities that matched people's abilities and preferences.

Is the service well-led?

Good

The service was well-led. The registered manager demonstrated leadership by example. There was a positive, inclusive and empowering culture at the service, which supported staff and in turn benefitted people using the service.

The service audited quality to help ensure good care was provided. Changes were made to the service as a result of any concerns being identified.

Norwood - 159a Station Road

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 12 and 17 August 2016 and was unannounced. The inspection was conducted by one inspector. Before the inspection, we reviewed the information we held about the service including notifications received. A notification is information about important events relating to the care provided which the service is required to send to us by law. We also checked the Provider 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 improvements they planned to make.

During the inspection, we were unable to acquire any feedback about the quality of the service directly from people using the service due to complex communication barriers. We used other methods to help us understand the experiences of people using the service. We spent time observing care in the communal areas such as the lounge and kitchen areas, and we looked around the premises. We spoke with three visiting relatives, three care workers, an assistant manager, the visiting communications advisor, and the registered manager. We looked at two people's care and medicines records, three staff files and training records, and various records kept for the management of the service including staff duty rotas, accident and incident records, and quality assurance records.

Following the inspection visits we spoke with a relative of a person using the service and two involved healthcare professionals. The registered manager also supplied us with copies of further documents such as policies on request.

Requires Improvement

Is the service safe?

Our findings

People's relatives raised no concerns with us about the safety of the service. However, we found that the fridge temperatures on the first day of the inspection were at 15 and 10 degrees Celsius respectively, with no action having been recorded as taken. Temperatures above 8 degrees Celsius could compromise the safety of food provided to people. Fridge temperature check records for these two fridges across the last three months indicated that the temperature was often above 8 degrees Celsius, regardless of the time of day that the record was made. No action was identified as being necessary in these records. Most recent checks within the weekly health and safety records incorrectly stated that temperatures were at appropriate levels, and where they stated inappropriate temperatures, there was no record of actions being taken.

At the end of our first day of visiting, the registered manager told us that in response to the above concerns, new fridges were being immediately ordered. We saw emails confirming this. She subsequently informed us that tests of the thermometers in use in the fridges indicated that they may not have been working properly. Whilst this may indicate that temperatures were in practice within safe limits, records did not demonstrate this or that action was taken whenever the temperatures were recorded as being too high.

We noted similar concerns across the previous two weeks with maintaining the medicines cupboard in the office, used for excess stock, at a maximum temperature of 25 degrees Celsius. Whilst ice packs were being used to attempt to bring the temperature down from 27 degrees Celsius, daily temperature records showed no sustained improvement. This had potential to reduce the effectiveness of people's prescribed medicines.

The evidence above demonstrates a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People's relatives said that there were enough staff working there. The registered manager told us that five staff worked until after lunch, then four for the rest of the day. One person had an additional staff member funded to work directly with them. At night, one staff member worked and another slept at the service but was available for emergencies. We checked the rosters worked in practice and found these levels to be upheld and occasionally bettered. The registered manager told us that there were some vacancies in the current staff team that were covered by some of the staff team working overtime, use of the provider's team of bank staff, and some use of agency staff. There was an emphasis on using the same replacement staff so as to better enable people's needs to be met.

The provider followed a recruitment procedure designed to ensure people were supported by staff who were suitable to work with them. The service was supported by a human resources office that completed recruitment checks before anyone was offered employment. These checks included Disclosure and Barring Service (DBS) disclosures, a minimum of two written references including from previous care employment, and checks of identity. Records showed that there was also an interview by the registered manager and a senior staff member along with checks of written ability and how the person interacted with people using the service when visiting for the interview. We fed back to the human resources department that records of exploring gaps in employment and checks of reasons for leaving previous employment were not always robust. However, it was encouraging that there were clear records of discussing any health concerns that

prospective applicants declared so that any service delivery risks were mitigated.

There was guidance on display for staff and other people about what constituted abuse and how to report matters. The staff guidance emphasised that suspicions of abuse must be reported. Staff were aware of their responsibilities to report suspected abuse, and how to escalate if they were concerned about inaction from managers. They confirmed that there was a duty system by which to phone a manager at any time of day or night if needed. We noted the service raised appropriate safeguarding referrals, and that there was learning evident from any such alerts, regardless of whether or not the local authority accepted the alerts. For example, recent staff meeting records showed actions had been taken to minimise the risk of a recent alert reoccurring and so promoting the safety of the person involved in the alert.

Staff told us how risk to people had been minimised when safety concerns arose. They said this resulted from in-house discussions, and that updated guidance and risk assessments were brought to everyone's attention via a designated file. They gave an example of someone having an alarm on the bedroom door that alerted staff when the person needed support. We saw that attention was paid to people's safety, for example, when getting into the house vehicle. We noted that there was a business continuity plan for the service and that an emergency evacuation bag was in place at the front door.

The service carried out individualised risk assessments that enabled people to take acceptable risks as safely as possible. These included for activities at home, within the community, and with being supported to move around. There were also health related risk assessments such as for epilepsy. The risks assessments were monitored, reviewed and adjusted as people's needs changed, and were brought to staff attention when changes occurred, for example, with one person's eating and drinking routines so as to avoid choking.

The premises had been adapted to promote safety. For example, there were window restrictors in use in upstairs rooms, and hand-rails to assist people to move around the premises where needed. There were records of regular fire safety checks by both staff and fire safety professionals. Action was taken where needed, for example, to address a malfunctioning fire door. Equipment was regularly serviced and maintained. An adapted bath had recently been installed, which enabled people to have easier access to bathing facilities. A record showed that one person had fallen in the old bath, and so the new bath was a positive response to their safety risks. The registered manager told us that it also benefitted another person who had not been able to use the old bath.

Staff told us they knew people living at the home very well, so were able to identify situations where people may be at risk or in discomfort and take action to address this. They said they shared information within the team about risks to individuals. This included discussing any new incidents at shift handovers and during meetings, along with writing accident and incident records. Records of these showed reviews by the registered manager on actions being taken to minimise the risk of reoccurrence. The registered manager noted that significant incidents were also directly reported to the provider for further scrutiny.

People's medicines were safely handled. Staff were trained on administering medicines to people, and records showed that their competency was regularly reassessed. The registered manager told us that the service had recently improved medicines management through switching to the BioDose monitored-dosage medicines system. For example, it included very detailed guidance for each medicine of each person. When the service first started using the system, additional tablets were found in one person's supply, but by using the guidance that included a picture of each tablet, the incorrect tablets were removed and the person received their medicines as prescribed.

People's medicine records were fully completed and up-to-date. Two staff signed for each administration,

which helped minimise the risk of errors. We found no discrepancies between medicines records and remaining stock, indicating that people received their medicines as prescribed. However, records of remaining tablets for separately-stored medicines such as paracetamol were not always accurate. We noted that a duplication of the administration records was sometimes taking place in these instances, which increased the risk of the inaccuracies occurring. The registered manager agreed to review and amend the duplicate system.

People and their relatives were satisfied with the safety and cleanliness of the premises. "It's always clean and tidy," one relative said. We looked at some people's bedrooms and saw no safety concerns. Communal areas, bedrooms and equipment were clean. The registered manager told us of some recent refurbishment work, and we saw evidence of this that improved on the appearance of the premises.

Good

Is the service effective?

Our findings

We received feedback that the service was effective. Relatives' comments included, "It's all very good" and "I'm very happy on the whole, she has a good quality of life." One relative added that their daughter was always happy to return to the service after visiting them, which they found reassuring.

People's care plans included sections for health and nutrition. Where appropriate, staff monitored what and how much people had to eat and drink, and what people weighed. We saw that fresh meals were cooked for lunch and tea, which staff and the menu confirmed as always occurring. Staff told us the menu was discussed and agreed with people using the service at a meeting each weekend. They also explained how they were supporting people to make healthily eating choices with the support of community health professionals such as dietitians. Recent records reminded staff about supporting certain people with specific healthy options, which we saw occurring in practice.

One relative told us of the service identifying some weight loss for their family member and of taking action to address the concern that arose. This included gaining dietitian advice and providing food supplements. They described staff as being "all hands to the deck" in working with their family member to stabilise the person's weight.

One person had recent guidelines in place from a community healthcare professional in respect of supporting them to eat safely and minimising the risk of choking. We saw that the guidelines were followed in terms of the consistency of the food provided. However, their drink could not have thickener added as stock had run out the day before we first visited. The registered manager explained and showed records confirming that a further prescription was on order but that there had been difficulties obtaining the thickener in practice. We saw that it was acquired the same day. We discussed this with the involved community healthcare professional and established that the situation did not present a significant risk to the person. As the process was new, we were confident that systems would be embedded to ensure that there was always a supply of thickener available for the person.

Records and staff feedback showed that one person was being supported to walk as much as possible in response to healthcare professional advice about maintaining this ability. The person's relative told us the service had made a referral for the professional input. The person had a walking frame that was adapted to meet their specific needs. Staff knew how to support them to use it safely.

Community healthcare professionals we contacted as part of this inspection said the service worked in co-operation with their advice. One of them told us that the service "were very quick to involve other professionals." Relatives confirmed that any health concerns were raised and discussed with them and the GP as appropriate. Records of such feedback praised the service for taking quick action and providing support to the person when they stayed in hospital. People's records demonstrated that referrals were made and the service regularly liaised with relevant health services. People had regular contact with relevant professionals such as opticians and dentists.

We saw that hospital passports were in place for people. These enable healthcare professionals to see what each person's health needs are and how to work with the person to meet those needs. They were readily available in case they were needed by the person at short notice. Individual health action plans had also been set up. The overall evidence indicated that people received good healthcare support in respect of their individual needs.

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 found that applications under DoLS were submitted and authorisations had been granted for some people, with no conditions in place. These applications were kept under review so that they did not go out of date.

Staff had received training on the MCA and understood the need to gain consent from people when providing care and support. We saw that people could refuse support. The registered manager emphasised that whilst the service had responsibility to keep people safe, it was fundamental that staff listened to decisions people were making including respecting consent refusals.

We saw records of there being best interest decision records for specific people where they did not have capacity to consent to particular procedures. For example, the GP had authorised for one person to be given medicine covertly through a best interests process. The service had a risk assessment and guidance for staff on how to follow this process. Staff told us that they continued to offer the person the medicine before providing it covertly. The registered manager told us there were capacity assessments and best interest records for where the service looked after people's money. However, whilst the service generally promoted people's freedom and did not keep rooms locked for example, there were occasional restrictive practices in place for individuals where the person's capacity to consent had not been recorded as assessed. For example, one person had bed rails in use and another person's cupboards were kept locked. Both processes were to minimise risk of harm, but neither had a record of assessing the person's capacity to consent to the procedure before moving onto a best interest decision. The registered manager agreed to review how the service worked in line with the MCA in respect of decisions such as these.

Staff spoke of receiving training online and in classroom settings. The online training included tests to check on sufficient knowledge, for which the registered manager informed us that staff received designated training days to complete the training. However, we found that some online training was incomplete across the whole staff team. For example, half of the staff team had not completed the online training on fire safety and on infection control. The registered manager told us that some staff struggled to complete and pass online training due to limited IT skills and the complexity of the courses. She added that recent staff leave and sickness had prevented some staff from having the time to complete the courses, and that the provider was converting some courses such as for fire safety into classroom-based training. She recognised that the training shortfalls needed addressing.

The provider had an induction process that followed the national Care Certificate's fifteen standards. However, records for one staff member in post for over five months showed that they had only completed five of the standards. The training was not taking place in a prompt manner.

However, we also found that staff at the service received some specific training that enabled them to better meet people's individual needs. For example, all staff had attended a three-day course on 'Great Interactions,' a course that focussed on improving engagement with and the autonomy of people using the service. They had also attended classroom-based courses on autism, supporting and encouraging positive behaviour, and providing individualised support.

"We had training on epilepsy yesterday," one staff member told us, explain that it was for a number of the staff team. They proceeded to describe the specific epilepsy needs of some people using the service. Another staff member told us of always taking out people's medicines when supporting those people in the community, in case of the need to respond to seizures. Records showed regular review of people's epilepsy with relevant healthcare professionals. This was a good example of how the service enabled staff to gain and maintain specific skills relevant to some people's needs.

On our second day of visiting, many staff were receiving moving and handling training in the service from a specialist trainer. This included use of the service's hoist. The registered manager explained that this was acquired to address the specific needs of a few people using the service. Therefore, whilst the provider's mandatory training was not consistently completed by some staff, staff received a range of additional training that helped to ensure that people using the service received effective and individualised care.

Staff told us of receiving regular supervision meetings, at least every two months, which records confirmed. Staff feedback indicated that staff meetings, supervisions and appraisals included opportunities to discuss how to better meet people's individual support needs and therefore individual and group training needs. For example, one recent staff meeting discussed in detail how to support one person with a developing health need. We saw records of staff consistently following a specific program in support of this matter. Staff feedback and records indicated that the matter was now in hand as the relevant community healthcare professional had confirmed improvements.

Outstanding ☆

Is the service caring?

Our findings

People's relatives told us that the service was very caring. Their comments included, "They do the care really well" and "Treating individuals with respect is at the heart of what they do at Station Road." We received similar comments from community healthcare professionals, one of whom told us that the service "went above and beyond in caring for my service user and nothing was too much trouble."

We saw staff had an excellent understanding of people's communication needs and interacted well with them. All staff received three days of a communication course called 'Great Interactions.' This helped staff to understand people's different communication methods such as using signs (Makaton) and information-carrying words. The provider's communications advisor attended the service as part of this process, to help recognise people's communication methods and develop strategies for staff to communicate better with individuals. We spoke with this person as part of the inspection. They praised the willingness of staff at the service to take on board the ethos of the training and to work in practice at engaging and improving communication with people using the service, which in turn helped people to develop independence and community inclusion.

People's care plans paid good attention to their communication needs and how staff should interact. One person's plan included various pictures of them signing and what each sign meant. Staff were guided to communicate in short sentences with another person, and to work through "social stories" with them to explain and reinforce appropriate behaviours such as not going into other people's rooms without invite. The plans also described ways in which the person agreed or disagreed, what the person likes to communicate about, and important people and events in their life.

The service had made significant efforts to help people communicate. Most people's rooms had adaptations by which to support with communication. These included a variety of small laminated pictures and symbols, known as PECS, by which to aid communication and provide structure for people with autism. Some people had communication books they could carry around which helped aid communication. We noted that in the hallway, the week's menu was displayed as a set of large pictures, along with photos of the staff working that day and what activities were planned for the week.

The registered manager and staff told us that the communication improvements had had positive impacts on people's involvement and participation in daily life. They gave examples such as someone now having as-needed medicine available when they showed evidence of being in pain, and of reductions of some people's behaviours that challenged the service due to being listened to and understood more. We saw this occur in practice, where staff and the registered manager worked together to understand the signs that one person was using, which clearly validated them and brought an end to the behaviours of frustration that the person was starting to exhibit.

The service had implemented a number of measures which had made positive differences to people's lives. Staff gave examples of how they enabled people to make choices relative to the person's abilities. This included offering people two physical choices that they could see, listening to people if they changed their

mind about an activity at the last minute, and printing movie pictures to help people decide what to watch at the cinema. One person was now planning the next day's events each night via a new picture board. Staff explained that this latter process was new, had been set up with the support of the provider's communication advisor, and was making a significant difference to the person in terms of giving them more control over their life.

Staff and the registered manager told us that people's independence was actively encouraged. This was particularly evident from 'active support' process, where people's skills for a particular activity such as getting dressed or taking medicines was broken into component parts and staff supported the person to undertake each part via the person's preferred communication methods. Records and staff feedback showed that this was helping people to develop specific independent living skills. Staff explained how some people were developing independence outside of this formal process, for example, with trying to operate the accessibility step for the house vehicle and with doing up their seat-belt themselves. Relatives confirmed that people's independence was encouraged within a safe environment. One relative said, "She now does things which I never thought she would be able to do." They gave examples of their family member attending community events, and explained that the progress was because their family member "is given as much control over her day to day life as her particular disabilities will allow."

Relatives were happy with staff continuity. "I know a lot of them," one relative said. Staff told us about discussing within the team what worked well to support people and what did not. This helped to, for example, identify when individuals were in pain. As one staff member said, "You need to pick up on the signs" that people gave, which they added occurred more easily with longevity in the service. The registered manager confirmed that over half the staff team had worked at the service for many years, and that this longevity helped people's subtle communications to be more easily noticed. Staff continuity, and our observations of positive staff interactions, demonstrated that positive and trusting relationships were developed with people using the service.

People were treated with respect and their privacy and dignity was promoted at all times. Staff supported people to attend to their appearance where appropriate. People had well-fitted clothing that suited them. People were provided with napkins where there was a risk of them spilling food or drink on themselves. Staff noticed someone with limited communication appearing cold and providing them with more clothing. Throughout the visit staff were communicating and interacting with people in a respectful and positive way. We also saw staff saying goodbye to people when their shift finished, which valued people as it helped them to realise that the staff member was no longer in the building.

We noted that people's personal information was stored and handled securely in the service. Whilst some people using the service came into the main office, confidential discussions such as the staff handover took place in private with the door shut.

Relatives told us the service kept them informed of significant developments with their family member. For example, when we spoke with one relative, they were aware of the epileptic seizures that their family member had recently experienced. They confirmed that the service invited them to their family member's formal review meetings and other formal meetings such as for college placements.

The service had an equality and diversity policy that staff were aware of, understood and had received training on. People's personal information including race, religion, disability and beliefs were clearly identified in their care plans. This information enabled staff to understand and respect people's needs, preferences and choices. The registered manager told us that the service followed Jewish food guidelines and provided Kosher food, standards of which were occasionally checked on by a local Rabbi. The

registered manager also told us that some people were supported to visit the local synagogue, and that people celebrated Sabbath and any other Jewish festivals with their family or people they lived with. A relative praised the support the service provided their family member in attending the synagogue, stating, "She loves going there and it is the type of thing she finds difficult but they have found a way to meet her needs and make it happen."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Feedback from staff and the registered manager demonstrated that they knew people's needs and preferences and so people received individualised care. Relatives confirmed that this was the case. One relative told us that their family member's "physical and mental health and emotional well-being are always at the centre of planning and this is done in a forward thinking way."

The registered manager provided many examples of how the service was responsive to people's needs and abilities, for which we saw corroborating records and observations. One person was being supported to manage their medicines independently. There were guidelines for staff on how to enable them to undertake the task themselves, and specific daily records that captured the extent of independence the person managed with each aspect of the task. The records demonstrated progress. Additionally, the registered manager told us that it became apparent that the medicines cupboard in the person's room was too high for them to easily access. It had therefore been repositioned. Other specific guidelines for people included for aspects of personal care, cooking, cleaning and undertaking laundry.

There were care plans for each person explaining what the aim was in respect of each particular care need, the person's abilities, how associated risks were managed, and how staff would provide support. These covered a range of relevant support needs including personal care, health matters, interests and communication. We saw that care plans were updated when needs changed, and were brought to the attention of staff. Staff feedback demonstrated their knowledge of people's particular needs and support plans, for example, around seizures, toileting support and communication skills. There were monthly reports for each person, which reviewed progress towards goals and other matters such as health and quality of life developments.

Staff told us people were supported with a variety of activities in and out of the premises. One staff member showed us guidance records they were developing for encouraging a greater variety of in-house activities. They explained that this was particularly for supporting people on quieter days. They were receiving support for this from the provider's communications advisor, to ensure that people's communication skills were recognised within the process. Staff meeting minutes showed that activity ideas were consistently discussed and that a summer holiday was booked for some people.

During our visit, one person was attending a college, another went out with members of the provider's service-wide sports team, and some people went to a local park via the house vehicle that supported people using wheelchairs. A number of people also visited family due to it being Shabbat, which was also celebrated in the service with a meal. Staff said that during term-time, people attended many more college courses, and that some sessions such as music therapy continued to occur across the summer. People were also supported with individual activities such as horse-riding, voluntary work and swimming. We saw records from relatives praising events held by the service for their family members such as a barbeque and a Chanukah party.

The service had a well-equipped and relaxing sensory room that one relative said had been recently refurbished. There was a comfortable lounge with large television and music system, and a well-furnished garden that people used. People's rooms were also pleasantly furnished, with sensory equipment in some cases. One person had particular activity equipment which responded to their eye movement. Their relative told us that the provider's IT department had helped train staff on using the device well.

Relatives told us that the service listened to any concerns they had and made adjustments to the care and support provided. "I speak with the manager and she deals with things," one relative said. The complaints policy and book were available for use in the entrance hall. We saw that it only had compliments from people such as, "An exceptional level of care" and "Staff are doing a brilliant job." The registered manager confirmed that there had been no complaints in the last year.

Staff told us, and records confirmed that, there was minimal reliance on as-needed medicines for working with people's behaviours that challenged the service. Staff said there was an emphasis on discussions within the staff team to try to identify what may have caused the person's anxiety, for example, a bad day out, a lack of activity, not being given choices, or too much noise. They tried to identify triggers to such behaviours and work positively with people before the behaviours emerged.

The registered manager told us that most people's behaviours that challenged had decreased in line with promoting people's autonomy, for example, allowing people to choose whether or not to go out, and through helping people to develop skills and independence. We saw that, where appropriate, people had positive behaviour support plans in place that were kept under review. These guided staff on recognising people's communications and trigger signs for developing behaviours that challenged the service, and on pro-active strategies of validating the person and addressing their needs. These values and processes helped to the service to learn from people's experiences and provide a more responsive service.

Good

Is the service well-led?

Our findings

Relatives spoke positively about how the service was led. A typical comment was, "It is a well-run home." They added that the registered manager "has a way of getting the best out of people and one can tell that the staff are happy and contented there. This makes things run smoothly and I can see the impact that this, in turn, has had on the residents." Community healthcare professionals fed back positively about the management of the service. One praised the registered manager and senior staff for their extensive working with one person using the service so as to "ensure her safety and well-being."

The registered manager demonstrated leadership by example. During the inspection she engaged with people, for example, speaking with one person about a health issue and later liaising with them about contact with their GP. We were told that she had helped one person to get up that morning. She told us that she would not expect staff to undertake any work that she herself would not do.

There was a positive, inclusive and empowering culture at the service. The registered manager praised the staff team's skills and commitment to meeting people's needs. She told us that she encouraged staff to take responsibility for their development, and so individual staff had formal responsibility for oversight and improvement of specific areas such as medicines, activities and menu planning. We saw examples of staff undertaking and developing these roles.

All staff we spoke with felt the service people received was good. They told us of service strengths including "teamwork and promoting a person-centred approach," of trying to meet people's individual needs and helping each other out, and of being proud about how the 'active support' process was helping people to be "more part of their own lives." Records showed that there had been a recent team-building day in support of promoting a positive working culture. The registered manager told us that teamwork was a strength of the service, and so, for example, everyone welcomed and supported new staff.

Staff told us they felt supported by the registered manager and senior staff, and were able to speak with them about any issues that arose. One staff member said that the registered manager "always listens to suggestions." We saw ways in which staff were valued. There were risk assessments around injuries to specific staff members that were brought to the attention of all staff so that everyone was aware of restrictions on that staff member's role. Staff members' religious festivals and their impact, as well as Jewish festivals in respect of people using the service, were discussed at staff meetings. One staff member told us the registered manager noticed and made enquiries if any staff were not their usual selves. Staff also said that supervisions included checks of how the supervisee was.

The service audited quality to help ensure good care was provided. We saw that questionnaires were sent to involved healthcare professionals and people's relatives in January 2016. Staff also supported some people using the service to answer easy-read surveys. Responses showed good feedback with occasional areas for improvement for which the registered manager gave examples of how matters had been taken forward.

There were some quality and risk audits used at the service that helped to drive service improvements. For

example, there was a medicines procedures assessment by a community pharmacist. We saw assessments of how staff interacted with people, to help ensure appropriate and effective communication and that the service responded to people's individual preferences and needs. We were shown an in-depth audit of the quality and security of people's finances and valuables that the service had responsibility for. There was also an overall service quality report by a senior manager that identified strengths and weaknesses from their visit. The registered manager had updated the action plan arising from this, to show that matters had been addressed. We found that many of these matters remained improved on, for example, that staff engagement with people using the service was much improved.

The service made changes as a result of identifying concerns. Where a medicines error occurred last year, staff told us about receiving further medicines training and competency checks. The approach to medicines management was also adjusted so that everyone understood that the staff members administrating medicines were not to be disturbed or try to do "two things at once." The registered manager told us that some classroom-based staff training was now taking place after the provider's online training was found not to work so well for ensuring staff knowledge of matters such as data protection and the Mental Capacity Act 2005. Record-keeping training had also been secured for the service due to some concerns identified with writing incident reports. Where a professional had identified health and safety issues, we saw that action had been taken to address the issues such as by there being a new kitchen work surface. We also noted that many of the plans the registered manager had set within the pre-inspection paperwork sent to us at the start of 2016 had now been addressed, for example, around refurbishment of specific parts of the environment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider failed to ensure that all premises and equipment at the service was properly maintained, as storage temperatures for food requiring refrigeration and for medicines were consistently too high. [Regulation 15(1)(e)]