Voyage 1 Limited

# London Road

## Inspection report

46 London Road
Gloucester
Gloucestershire
GL1 3NZ

Tel: 01452380835
Website: www.voyagecare.com

Date of inspection visit:
09 June 2017
13 June 2017

Date of publication:
21 August 2017

## 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? | Requires Improvement |

# Summary of findings

## Overall summary

This inspection took place on 9 and 13 May 2017 and was announced. The last inspection of the service took place in November 2014 and the service was rated GOOD.

London Road is registered to provide two regulated activities; accommodation for persons who require nursing or personal care and personal care. The care home is registered to provide long and short-term care to 10 people with acquired brain injuries. At the time of the inspection there were 10 people living there. The service does not employ nurses so people's health needs were met by visiting health care professionals, for example, community nurses. The accommodation had been adapted to meet the needs of people who live with a physical disability. People's private accommodation comprised of a bed-sit arrangement with washing and toilet facilities and a small kitchenette. The second service supports people with their personal care. They live as a small group in the community. At the time of the inspection three people lived together.

A registered manager manages both services with the support of their senior staff team. 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.

Monitoring processes were in place which ensured care and support was provided in both services, safely and to a high standard. We have however, made a recommendation in relation to the service's audits.

There were arrangements in place to keep people safe. There were enough staff in both services to ensure people's care needs were met and to support them with other daily activities. Safe staff recruitment practice protected people from those who may not be suitable to care for them. People in both services received the support they needed to take their medicines safely.

Staff had been provided with appropriate training and support to meet people's diverse needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in both services supported this practice. People who lacked the mental capacity to make decisions and provide consent for their care, treatment and accommodation were protected. This was because staff adhered to the principles of the Mental Capacity Act 2005. People were supported to maintain their nutritional well-being.

People's individual choices and preferences were met. People had a voice and were listened to. People therefore received care which was tailored to their individual needs. People were treated with respect and their privacy and dignity maintained. They were supported to maintain relationships with those who mattered to them. There were no unnecessary restrictions applied to when relatives and friends could visit or to people's social lives. People were supported to take part in activities they enjoyed.

People's care was planned and reviewed with the involvement of the person (where possible) and relatives and representatives (where appropriate) were fully involved. Care and treatment records were well maintained and gave staff and visiting professionals the information they needed in order to support people's needs. People's goals and aspirations were incorporated into these plans and supported.

There were arrangements in place for people to be able to raise a complaint or concern although the registered manager informed us they had not received any. Communication with people, their relatives/representatives and staff was good so this ensured that any queries or worries were addressed and resolved quickly. People's views and suggestions were sought as were those of their relatives/representatives. These were acted on to improve the overall service.

## 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.

People received their medicines safely and when they required them.

People were protected from potential abuse because staff knew how to identify this, report any concerns and manage safeguarding processes.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

People were protected against risks that may affect their health. Environmental risks were also monitored, identified and managed.

There were arrangements in place so people lived in a clean environment which helped to protect them from potential infection.

### Is the service effective?

Good

The service was effective.

People's health needs were planned and met. They had access to health care professionals and specialists when needed.

People received care and treatment from staff that had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.

People were supported to make their own decisions and staff asked for people's consent before they provided care or treatment. Where people were unable to do this their care was provided lawfully because staff adhered to the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009).

People received appropriate support with their eating and

drinking and were provided with a diet that helped maintain their well-being.

## Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who were genuinely interested in people's well-being and happiness.

People's preferences were explored and met by the staff where possible. Care was planned around people's individual choices and wishes and therefore was particularly personalised.

People's dignity and privacy was maintained and their human rights upheld.

Staff helped people maintain relationships with those they loved or who mattered to them.

## Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed with their involvement. People's relatives or representatives were fully involved in this process where it was appropriate.

People had opportunities to socialise and take part in activities which were meaningful to them.

There were arrangements in place for people to raise their complaints. However, open communication with people and their relatives helped to ensure small worries and areas of dissatisfaction were quickly resolved.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

There were arrangements in place to monitor the service and standard of care provided to people, although, some of the audits used by the service were not always effectively identifying areas for improvement.

People and staff were encouraged and supported to be involved in developing the service. Their views and suggestions were sought after and these contributed to the decisions made about what took place and what happened in the service.

People and their relatives had access to the registered manager and her senior staff when they needed it.

People were protected from poor care and services because there were monitoring arrangements in place. These assessed the service's performance and ensured improvements were made where necessary.

# London 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 9 and 13 May 2017 and was announced. The provider was given 48 hours' notice because the main care home provides care to 10 people who spend a lot of time out of the home taking part in activities. The service also provides supported living to three people in a different location. This was the first inspection of that part of the service. We therefore wanted to know if people and staff in both locations would be available. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the information we held about the service since the last inspection. This included statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. A Provider Information Return (PIR) was not requested prior to the inspection and we gathered this information when we inspected the service and made the judgements in this report.

We gathered information about people's experience of the service by talking with four people who lived in the care home and one person who lived in the supported living location. We also spoke to two relatives. We spoke with the registered manager, two team leaders and two care staff at the care home. We spoke with one member of staff at the supported living location. We sought the view of one health care professional who visited the care home. We sought feedback from local commissioners of the service.

We reviewed records and documents which included: support plans and risk assessments relating to two people who lived in the care home and one person who lived in the supported living location. We reviewed the records of two other people which related to the Mental Capacity Act 2005. We reviewed three staff recruitment files and the staff training record. We reviewed a selection of medicine administration records in the care home and one in the supported living location. We also read the provider's medicine administration procedures. We reviewed a selection of audits as well as the service's current action plan. We reviewed the fire evacuation arrangements and the guidance on this for staff. We reviewed maintenance records at the

care home.

Good

# Is the service safe?

## Our findings

People received their medicines as prescribed and when they needed them and people's medicine administration records (MAR) confirmed that they had received their medicines as prescribed. Medicines were stored securely and good arrangements with the supplying pharmacy ensured these were available for people. Staff had received training on how to administer medicines and their on-going competency in this task was checked. Additional training was provided to administer medicines, for example, through a percutaneous endoscopic gastrostomy – PEG (a medical procedure in which a tube is passed into a person's stomach through the abdominal wall so food, fluid and medicines can be received). The administration of some anti – convulsion medicines had also required additional training. Arrangements for the safe administration of these medicines were seen. Guidance for the use of medicines prescribed to be administered "as required" was not always seen alongside the person's (MAR). This had been incorporated in their relevant support plan and staff administering people's medicines were familiar with people's ''as required'' protocols. The registered manager however, told us the protocols would be moved and put alongside the MAR for easier staff reference.

There were arrangements in place to keep people safe. People were protected from potential abuse because staff had been trained to understand what constituted abuse and how to report relevant concerns. Staff knew who to report any concerns to and team leaders knew how to manage the provider's safeguarding processes. The provider's safeguarding policy and procedures worked in line with those of the local authority. Relevant information was therefore appropriately shared with relevant agencies and staff worked with other professionals to safeguard people. Discrimination of any form was not tolerated.

People were given opportunities to talk about any concerns they may have. With this in mind we asked one person, if they felt safe. They told us they felt "very safe." Another person told us they would tell staff if they had any concerns but they said, "I have no qualms." The person we spoke with in the supported living location told us they felt able to talk with the senior staff or the registered manager about anything that worried them. A professional boundaries policy had been introduced. There was therefore an expectation from the provider for all staff to behave professionally and to have appropriate working relationships with those they looked after and worked with. We observed staff behaving in a professional way throughout the inspection.

Other policies, procedures and practices were designed to safeguard people and keep them safe. For example, safe recruitment of staff and staff's ability to whistle blow (report concerns without fear of reprisal). We reviewed three staff recruitment files; two staff worked in the care home and one worked in the supported living location. These showed appropriate checks had been carried out prior to their employment. Checks included clearances from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults or children. Relevant references had been sought and previous employment histories explored. These checks assist employers in making safer recruitment decisions.

People's needs were met as there were enough staff in both locations to do this. In January 2017 the registered manager had put forward a case for additional staff in the care home. This had been agreed to by the provider and met through successful recruitment. We spoke to two staff who told us they had been supported well following their recruitment. They had been given time to read the provider's policies and procedures and learn about safe working practices.
Staff in the supported living location had worked as a team for several years and operated as a separate team from the one in the care home. A member of staff there said, "We are like a family unit (meaning people and staff) so this gives people structure and continuity." They also said, "We tend to cover each other's holidays and days off so there is always someone here." The registered manager told us she had covered a shift recently at this location, but she confirmed that the need to do this was very rare.

People's monies were kept safe. Monies were checked on a daily basis in the care home and further monthly audits completed at both locations. The provider's finance staff also completed an annual audit. Any money held on behalf of people was stored securely and income and expenditure was checked against the total amounts held. During the inspection we observed one of these checks taking place. People who managed their own spending money had access to this when they wanted it.

People were protected against risks which may impact on them. In the care home we looked at how risks relating to fire and potential bacteria in the water system, such as Legionella, were assessed, monitored and managed. The fire risk assessment had been reviewed in December 2016 and there were no actions to be completed from this. A Legionella risk assessment was in place and specialist contractors were involved in maintaining the good health of the water system. There were no required actions from their last visit in May 2017. Staff in both locations had received training on fire safety and in the care home, people's personal emergency evacuation plans (PEEPs) stated what assistance they required in the event of an emergency, such as a fire. The registered manager told us what the agreed procedure was for the day and night-time. The arrangements for the night time needed to be added to the guidance for staff as this differed from the day-time which was recorded. The registered manager told us she would address this recording oversight straight away.

Any accidents or incidents which took place in either location were reported electronically to the provider. Although the immediate risks were assessed and managed by the registered manager or a team leader, a level of risk was determined through the provider's electronic system. These incidents/accidents were followed up by the provider's head office to ensure appropriate actions and reporting had taken place. Actions which were subsequently taken by the staff were also fed back to the provider. The provider's process analysed the information received and looked for trends and patterns. This helped to ensure the actions being taken were preventing reoccurrences. We followed the reporting process for one incident which demonstrated the above process had been fully completed. The registered manager described it as a "helpful and good on line system." The service's responsibilities under Duty of Candor were discussed. The registered manager was fully aware of the need for accountability, honesty and transparency following an accident or incident. These responsibilities had also been discussed with the staff.

Risk assessments clearly stated what the potential hazard was and what needed to happen to reduce risks to people. For example, we saw risk assessments relating to how people needed to be moved and their safety when eating and drinking. We read the risk assessments and support plans of two people who lived in the care home who were at risk of choking. For example, one person's relevant support plan gave clear guidance on the texture of their food and drinks to prevent them from choking. It gave guidance on how the person should be positioned before they ate and drank. Staff had received specific training on how to manage choking incidents during their First Aid training. Risk assessments were also seen in the supported living location which were relevant to people's needs and activities. For example, safe use of the kitchen, the

community and any dietary risks.

Maintenance responsibilities were jointly held by the registered provider and the landlord for both locations. The registered manager explained the process for requesting maintenance support from either and reported issues were resolved fairly quickly. Staff completed various health and safety checks which were then reported to the provider. These included for example, necessary water temperatures in relation to the health of the water system and risks related to potential scalding. A spreadsheet was kept by the registered manager on all health and safety checks so there was a system in place to monitor the completion of these. Contracts with specialist contractors were in place to ensure on-going maintenance and servicing took place. For example, of the equipment, fire alarm system, lighting systems and use of utilities.

People were protected from avoidable infection because there were measures in place to prevent the spread of infection. For example, soiled laundry was segregated and washed on an appropriate cycle to ensure all potential germs were eradicated. We saw colour coded cleaning equipment in place, which distinguished which cleaning equipment should be used where. This prevented cross contamination between areas such as the kitchen and toilets. Staff wore protective clothing; aprons and gloves for example, when delivering personal care and when preparing and serving food. The care home looked tidy and clean and one relative said, "[Name's] flat is always spotless." Staff were vigilant and monitored people for any type of infection and acted on symptoms quickly. The provider supported staff to obtain necessary vaccinations such as Hepatitis B to protect people and themselves and, then required evidence that this had been obtained (Hepatitis B can be transmitted through contact with blood or other body fluid infected with the virus).

Good

# Is the service effective?

## Our findings

People and relatives told us they were happy with the standard of care provided to them. One person said, "They (staff) provide very good care. I'm satisfied, I can't think of any improvements needed. My GP is got when I'm feeling poorly." Another person told us how well they felt supported and they said, "The facilities are good." When speaking with two relatives about their relative's care they said, "It's very good, we can't fault the care or the staff." One health care professional confirmed that staff had good knowledge of people's health needs.

People's health care needs were met. Staff worked with many other health professionals. People's health plans recorded their health related needs and gave guidance to staff on how these were to be met. People were supported to live well with what were, in some cases, complex health needs. The services provided to people and how their specific disabilities were met at London Road had been reviewed by the local authority in January 2017 and they confirmed with us that they had no concerns. The registered manager explained that one GP tended to carry out all regular visits and reviews of people. They described their support as being "fantastic". They said, "They know all individuals and understand them and their needs very well." They also reported a good working relationship with local community nurses.

People's records showed they had also been referred to specialist practitioners where needed. The registered manager told us access to these specialists was usually through the local NHS head injuries team, which they described as being "very good." This included access to and visits by speech and language therapists, physiotherapists, occupational therapists, neurology specialists and mental health practitioners. When appropriate the service also liaised with the community learning disability team. People, including those living in the supported living location were supported to attend health related appointments. People also had access to foot care, opticians and NHS dental care.

People were cared for by staff who received training and support to be able to meet their needs. We reviewed the service's electronic training record which recorded staffs' training in subjects which the provider considered to be necessary for staff to practice safely. For example, training in fire safety, first aid, infection control and safe moving and handling were some of the subjects covered. Further training was completed by computer. Face to face training was also completed and provided. The registered manager sourced additional training as needed. This had included for example, the management of PEGs and nail care. This demonstrated that staff received a good mix of relevant training which they confirmed met their needs.

All staff received training when they first started work for the provider, which two staff told us had been "very good". On-going training and competency checks then took place. Staff received regular support sessions where they were able to discuss their learning and support needs and receive feedback on their progress. The provider's expectation was for staff to receive these at least four times a year or more if required. The record which recorded the staff support (supervision) sessions was not up to date for staff working at the supported living location. According to the record there had been no supervision session since March 2016. However, a member of staff who worked at this location showed us evidence of recent supervision sessions

having taken place. They also told us they received regular supervision from the senior member of staff at this location, as did their colleagues.

People in both locations were supported to make their own decisions related to their care, treatment and daily living. Where it had been possible they had been involved in the decisions made about where they lived. The relatives of one person told us their relative was able to make independent decisions. They said the fact they were able to make such decisions had been "very strictly observed" by both the staff in the care home and the person's placing authority. This person's wish and, significant decision for them, to live in Gloucestershire and at London Road had been respected and met by their funding authority. Another person had been involved in the decision to live at London Road until their longer term plan could come to fruition.

Where people had been unable to make these decisions we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. We also checked that the provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the Deprivation of Liberty Safeguards (DoLS). The care home had concise records in place which demonstrated well that these principles were followed. We saw mental capacity assessments had been completed in relation to specific decisions. Decisions made on behalf of a person had then been made in their best interests. Best interests decisions had been made by appropriate people. For example, a decision to insert a PEG into one person had been made by their GP. However, their family members and the staff caring for them had also been consulted. In relation to this person's finances a representative had been appointed to manage these through the Court of Protection.

In other people's records we saw similar process had been followed in relation to other aspects of people's care and treatment. The training record stated staff had received training on the MCA; new staff had yet to receive this training. The well maintained MCA paper work and the support plans showed that staff understood how to put the principles of the Act into practice. The same principles were applied to those who lived in the supported living location. The person we spoke with in this location was able to make independent decisions, with support. Their support plans stated that "decisions are made in partnership with [name]". For example, the person's records showed and they told us, that they had been supported to know what foods they could eat to maintain their health. They therefore made daily decisions, with support from the staff.

In the care home, where people had been unable to provide consent to live there, but needed to in order to receive the care and treatments they required, the principles of the MCA were adhered to. Following assessment of people's mental capacity in relation to this decision, applications to a 'supervisory body' for authority to lawfully deprive them of their liberty had been submitted. For example, we saw one person's application had been authorised and DoLS were in place. Staff understood what support was needed to ensure these safeguards were upheld. Another person's DoLS application was being prepared. They had just had their mental capacity assessed by a psychologist in preparation for this.

Staff also applied the least restrictive options when supporting a person. For example, one person had a DoLS authorisation in place, but when they wished to go out they were taken out with a staff escort. Staff were also aware that 'supervision and control' could constitute a deprivation of liberty. In general practice staff were careful to afford people opportunities to be independent, to make the decisions they could independently or with support, to receive visitors and to mix socially so restrictions on people were limited.

People were supported to maintain their nutritional well-being. People's appetites were monitored to

ensure problems relating to this were picked up quickly and referred to the GP. People's weights were also monitored. People decided on what they wanted to eat, both on an individual basis and together in the weekly house meeting. On the day of the inspection one person had chosen not to eat the main meal and an alternative was prepared for them. People had access to snacks and drinks in-between meals. People's accommodation had individual kitchenettes where they or relatives could prepare food and drinks if they wished to. At the time of the inspection the majority of people made individual choices at breakfast and lunch time but chose to eat all together in the evening. We observed people receiving support to eat their food and to drink. This support was given in such a way which maintained the person's dignity. The meal time we observed was a social time with people and staff chatting and laughing together.

Good

# Is the service caring?

## Our findings

People and their relatives told us the staff were kind, caring and genuinely interested in their well-being. Some people referred to the staffs' commitment to supporting them to get the best out of their lives as they could. For example, one person said, "The staff set a creative dynamic and it really works for me." Another person told us, "The best thing are the staff and that is from the bottom of my heart." Another person told us they were "happy here" and said "the staff are very kind." Another person said, "They help me get up and sort myself out." The relatives of one person spoke highly of the staff and said, "We think of them as relatives." Two staff who had worked previously in other care locations said, "It's a really nice place to work; it works well here. There is a nice atmosphere; it's like a family group." One health care professional commented that the staff team were "totally caring".

People told us and we observed that they had very positive relationships with the staff. Staff interactions with people were respectful, kind and inclusive in both locations. Staff spoke to people and listened to them when they were around them. Some people communicated verbally and some people used assistive technology. In all cases staff were observed to be patient and gave people the time they needed to communicate. Staff knew people well so where communication was difficult staff knew what their non-verbal communication meant. The people staff looked after genuinely mattered to them. One person's relatives said, "[Name] sees it as home. When we are out [name] will start to say, when am I going back?, there is a longing to be back – home."

People's diverse needs were recognised and to meet these specific needs people's care had been personalised.  People were therefore at the centre of the care planning and care reviews. People's individual choices, wishes and preferences had been explored and incorporated in to this. People had been listened to. The relatives of one person explained how they were involved and could contribute to their relatives care reviews. They said staff were "totally inclusive" of them. However, they said, "They [staff] always leave the choice to [name]." This person said, "I can do what I want to do, I can be independent." Another person explained they were able to live independently but they were also able to see their relatives when they wanted to. People's right to private family life and correspondence was upheld. People were able to receive visitors when they wished and meet with family and friends outside of London Road. The same rights applied to people living in the supported living location.

We observed people making choices and doing what they wanted to do in both locations. The person we spoke with in the supported living location told us they were free to go out and do what they chose to do. On the day we visited this location they had decided to stay in but had been out on other days. People in both locations made choices about what activities they took part in and what tasks around the home they wanted to get involved with. In the care home some people enjoyed helping in the kitchen and were supported to do this.

People's privacy and dignity was upheld. All personal care and treatment, in both locations, was carried out in private. One person said, "My care is delivered in private." We observed staff maintaining people's privacy and dignity when they spoke with them. Care and treatment issues were not discussed with people in public

for example. All care records were kept secure and information about people, confidential. The registered manager told us that any specific cultural or religious beliefs were respected. However, no-one had any specific needs in this sense at the time of the inspection.

Good

# Is the service responsive?

## Our findings

People told us the service was responsive to their needs, goals and aspirations. There were well written and well maintained support plans, in both locations, which outlined what people's needs were and what support they required to meet these. Apart from health needs, support plans also recorded how people's personal care, social needs and activities were met. People's plans included their goals and aspirations. These records were highly personalised and helped people's care be tailored to their individual needs. There was evidence to show in people's records that where people wanted their relatives involved in the planning and reviewing of their care they had been given the opportunity to be so. Where people did not want family involved in this, staff respected this. These records ensured the staff and visiting health and social care professionals had up to date information about people. This protected people from unsafe or inappropriate care and decisions being made due to a lack of accurate information about them.

People's diverse needs were recognised and included in the planning of their support. People's mental health was protected and supported and support plans recorded how this would be done. People were at the centre of the care and support staff provided, meaning they received care which had been tailored to their specific needs. In one particular case the registered manager and senior staff planned and delivered the person's care in conjunction with care staff employed by the person. This person and their relative were fully involved in any plans made and in reviewing and altering care as needed. People's individual choices and preferences had been explored and incorporated. People's wishes had been listened to. The relatives of one person explained how they were involved and could contribute to their relative's care reviews. They said staff were "totally inclusive" of them. However, they said, "They [staff] always leave the choice to [name]." This person said, "I can do what I want to do, I can be independent." This meant that this person had full control over how they received their care. Another person explained they had the level of independence they had because their support was so well planned.

People were supported to take part in activities which were meaningful to them. They were also supported to use the wider community and to get involved with things going on within it. The registered manager explained that most people were out and about most days. Some people had access to a day centre which worked with people with acquired head injuries. Other clubs, groups, shops, restaurants and local places of interest were accessed most days by people. On the day of the inspection, in the care home, we observed staff going in and out escorting people or dropping them off and collecting them later. One person had decided they wanted to visit the local Cathedral so they had been supported to do this by a member of staff. Another person had been out with relatives. Their relatives said, "The staff take [name] out and [name] has a lovely time." In the supported living location two people were out when we visited. People also belonged to day centres and various groups and clubs. The person we spoke with told us they enjoyed going into the main town.

People in the care home had opportunities to use some of the facilities at a local collage for physically disabled people. This in particular provided facilities for swimming. An art therapist from the college also attended weekly to facilitate an art group. Links had been made with a local main stream college and people had completed computer related courses there. The registered manager had introduced an in-house

therapy co-ordinator role and this member of staff helped people with their activities. One person had wanted to increase their experience and use of IT beyond what was available for them at the local college. The therapy co-ordinator had worked with this person on their IT and photography skills. This had enabled the person to still take part in an activity they enjoyed and to develop their skills further. As a result the person had taken on the role of editor of the London Road newsletter. This went out to everyone in the home as well as relatives and visitors. A music therapist also attended the care home and we saw musical instruments, which included a full drum kit, in a communal room which had been turned into a dedicated space for physiotherapy and people's activities.

People were supported to go on holiday. One person's aspiration had been to visit a certain place in a particular country. The registered manager told us goals had been set and they had helped this person meet these and achieve their trip. This person they told us about their achievement with great pride. Another person had a clear goal which they hoped to achieve in 2018. Where we have reported above about staff working with a person's own privately funded care staff, this was work being done to help achieve this. We spoke with another member of staff who had been involved in supporting another person to take a long haul flight to somewhere they had always wanted to go to. The registered manager told us that people who wanted to visit places in the world and take holidays were supported to do this despite their disability. Sometimes staff went with them and other times they went with their families. The provider allocated an amount of money, each year, for each person, towards a holiday. The registered manager told us people took a holiday each year and although this took a lot of planning and organising people's aspirations and equal opportunities, in this sense, were met.

There were procedures in place which enabled people, their relatives/representatives and other visitors to raise a complaint or express an area of dissatisfaction. The provider's complaint procedure was in a prominent position for visitors to read. People were provided with guidance on how to make a complaint when they first went to live at London Road. Information about how to make a complaint was also available to people in the supported living location. The registered manager told us they had not received any complaints. They explained that they took a proactive stance with regard to making sure people and relatives had access to them. This enabled any queries or concerns to be expressed and addressed immediately. People and relatives confirmed they could always speak with the registered manager when they needed to. The registered manager told us communication and feedback was exchanged by email. There were procedures in place for any complaints or concerns to be reported to the provider and these would then be followed up by a representative of the provider to ensure they had been appropriately managed and resolved.

Requires Improvement

# Is the service well-led?

## Our findings

The provider had quality monitoring systems in place which allowed them to monitor the standard of service and care being provided. This process also checked the service's performance against the provider's expectations and required levels of compliance with relevant regulations. A representative of the provider visited on a regular basis to provide support to the registered manage and to check on the service's performance. They were also able to swiftly implement any required improvements required for compliance or to demonstrate best practice.

We saw a selection of audits which the registered manager and their staff completed. These were recorded and sent to the provider including the actions devised by the registered manager to address any areas of required improvement. The audits used by the service however, had not effectively picked up some of the anomalies we identified in relation to recordkeeping. For example, people signing their medicine administration records instead of staff at the supported living location. The provider's medicines policy and procedure was not clear about who should sign the MAR once the medicine had been administered. An up to date record of staff supervision sessions taking place at the supported living location was not available and the night-time guidance for staff in relation to evacuation of the building was not recorded. A representative of the provider took action to ensure staff completed the MARs and the registered manager informed us that all other records would be updated and completed.

We recommend that the service seek advice and guidance from a reputable source, about the effectiveness of the audits in use by the service.

The last quality assessment by a provider representative was completed for the period April – June 2017. This assessment followed the five key areas of inspection used by the Care Quality Commission (as followed in this report). In some areas the service had scored under the required one hundred per cent, but the provider's expectations were set high so relatively minor omissions could affect an overall score. For example, an incorrect document had been used by staff to complete some health and safety related checks. These high expectations however, afforded people protection from inappropriate and unsafe services. The monitoring assessment showed the service had scored one hundred per cent in 'Caring'. This had been based on an assessor's observations on how for example, people's dignity had been upheld and how respectful staff were towards people.

Actions from the registered manager's audits and from the provider representative's visit were consolidated onto one action plan. We saw the current action plan being worked on by the registered manager. Some actions had already been completed and some were still work in progress. The registered manager explained that the actions would all be completed before the next provider representative visit, due at the end of June 2017. Actions were signed off by the registered manager once completed and the provider representative checked and evidenced the improvement. An annual audit was completed both by the registered manager and provider. We were told this covered all of the provider's key performance indicators and checked that actions were leading to full compliance and improvements. A quality audit had been completed by local commissioners in April 2017. They reported there were "no major issues" following this.

People told us they considered the service to be well managed. One health care professional commented that the service had an "excellent manager". The registered manager had managed the service since 2005 having worked their way up from being a care assistant. They had a lot of experience therefore in looking after people with disabilities. They also told us they understood what each role in their team was like and they remained aware of this when supporting their staff. People said, "[Name of registered manager] is perfect she does what needs to be done in a very effective way." Another person told us the registered manager was "really good." Relatives spoken with said, "[Name of registered manager] is always receptive to comments and over the last few years things have improved." A member of staff told us, "[Name of registered manager] is really supportive and easy to talk with."

The registered manager told us the provider's systems and processes had improved over the years and they now provided them with a lot more structure and support. They spoke of good support being provided by their immediate line manager who they could contact at any time when needed. The registered manager was an experienced manager and at the time of the inspection, was helping to support one of the provider's sister services.

People were actively involved in helping to develop the service and to make decisions about what happened there. Weekly house meetings were held where everyone got together and discussed generally what was going on in their service. This included planning the forthcoming week's menus, activities, events and appointments. Staff meetings were also held on a regular basis and the registered manager attended some of those held at the supported living location. They explained that staff from this location often called in whilst passing by or with the people they were supporting. People living at the supported living location had previously lived in the care home so they knew people and staff there and liked to visit. The registered manager spoke with the senior member of staff from the supported living location on a weekly basis. They provided her with an up to date report on what was happening there and they often called into the care home to deliver necessary documents and records. There was therefore good communication between the two locations.

The registered manager was very involved, on a day to day basis, with people's care and worked alongside staff in the care home. They were therefore fully aware of the staff culture and any issues people had. People referred to her as being very approachable and always available when in the care home. Staff told us her door was always open and we observed staff feeling comfortable enough to enter the office and talk with her when they needed to. Feed back in 2016 about "what's not working" highlighted that the "communication link" was missing when the registered manager was not in the care home or on leave. The registered manager told us this had been addressed partly by recruiting more care staff and partly by ensuring there were enough appropriately experienced team leaders in place to take a lead when they were not present. The registered manager told us relative meetings were not held as parents and relatives either visited on a regular basis or communication was achieved through email or telephone.