Vibrance

Pinewood & Hollywood

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The unannounced comprehensive inspection of this service took place on the 4th of March 2016. Pinewood & Hollywood provides accommodation and personal care for to up to eight people who have a learning disability across two bungalows on the same site. At the time of inspection Pinewood was home to three people and Hollywood was home to four people using the service.

A long- standing registered manager was place. 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.

This service was rated as Good in all domains and had some excellent features.

Staff supported people at the service achieve their potential and pursue hopes and dreams though collaborative working, and innovative thinking and planning. This helped people to experience a level of care and support that promoted their wellbeing and encouraged them to enjoy a stimulating and meaningful life. The registered manager and staff team were passionate about providing exceptional care. Maintaining the privacy and dignity of people was exceptionally important to staff at the service.

Staff worked creatively and collaboratively with other health and social care professionals and outside agencies to make people's hopes and dreams a reality. Care professionals were very positive about the service.

The service provided excellent and innovative care and support to people to achieve their potential though collaborative care plans based on their individual hopes and dreams. When risks to people were identified, the staff worked to mitigate risks using creative problem solving, whilst still supporting people to achieve maximum independence. When risks had been identified, that this did not prevent the people at the service from achieving their potential.

The service ensured that staffing levels were good and that there were enough staff to meet people's individual needs. The service had retained a strong core team of staff who knew people at the service well. Staff told us that they loved their jobs. The registered manager increased staffing when people were deteriorating in health or at the end of their life. The service had safe and robust recruitment procedures and people who lived at the home were involved within the process.

The management team had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated excellent awareness of capacity and DoLS. Capacity assessments were regularly reviewed, and completed to ensure that they remained relevant. People who lacked capacity had best interest's assessments in place and advocacy was involved in addition to people's relatives.

People at the service could not always vocalise what they liked about the service due to their disabilities, however they were keen to show us their bedrooms, and photos of activities they had carried out. It was evident in interactions that people felt very well cared for and supported.

Relatives were extremely positive about the care their relative received and where involved in all appropriate aspects of their loved ones care. Relatives told us staff were extremely approachable, available, and willing to listen. They were encouraged, and supported to come to family gatherings at the service to get to know each other to develop support networks. Relatives told us they felt part of a extended family.

Staff demonstrated affection and warmth in their relationships with people, and people were happy and comfortable in the company of staff. We saw people at the service demonstrating warmth to staff in return.

Staff were lead by a manager who acted as excellent role model and who embedded the organisations values. Staff had clear philosophy that they were guests in people's homes. Staff spoke to people as equals, seeing past the disability to the person. When people had presented with a change of behaviour, agitation, or had been challenging, staff investigated what might have distressed the person and worked hard to reduce the distress. This at times included close liaison with other services to find innovative ways to support people.

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

All staff had been trained in safeguarding vulnerable adults and had a thorough understanding of reporting procedures.

Staff identified risks to people through creative problem solved risks to support people to achieve their potential.

When people lacked capacity to manage risk, individualised, collaborative and creative care plans were developed to support the person to achieve their potential.

The service managed medications safely.

Excellent procedures were in place to ensure staff competency in the administration of medicines.

The service had robust infection control systems in place.

Is the service effective?

Good

The service was effective

Staff had a robust training induction which included a comprehensive application of the Care Certificate.

Staff had access to additional training and shared their knowledge with others constantly drive up standards of care.

The management team promoted continuous learning for staff and carried out regular observational checks to ensure competence.

The service had "Champions" for complex conditions that provided staff with up to date knowledge.

The management team shared up to date clinical developments with staff to continuously improve and develop care.

People at the service chose the meals they wanted and had a varied, nutritional diet, freshly cooked and prepared by staff and

people at the service if they were able.

Staff had excellent understanding of Mental Capacity Act, Deprivation of Liberties (DOLS).

Meaningful, relevant, and collaborative capacity assessments were in place and reviewed regularly.

Is the service caring?

Good

This service was very caring.

The staff team were motivated to develop creative ways of seeking people's views and encouraging communication

We observed positive and compassionate interactions between staff and people at the service. It was clear that people thoroughly enjoyed staff company.

Relatives told us that the service was a second family to be people, and that people were loved and nurtured to achieve their potential.

Staff at the service understood that they were guests in people's home and treated people with dignity and respect at all times.

Staff intuitively understood people's needs due to their exceptional understanding of people at the service.

Staff used a variety of methods of communication that were creative and holistic to ensure that people could express what they needed.

Is the service responsive?

Good

The service responded to people's needs and preferences

People received care that was flexible and responsive to people's individual needs and preferences.

Staff were creative in enabling people to live as full a life as possible and to achieve their hopes and dreams.

Care plans were exceptionally personalised and people and their families had been involved in developing these.

Staff used innovative and individual ways of involving people so that they were consulted, empowered, listened to and valued.

People had access to a wide range of meaningful activities.

The registered manager had developed strong relationships with other services to facilitate these things a variety of new opportunities for people.

People were encouraged to be part of their local community and to integrate into community groups in the area.

Is the service well-led?

Good

The management and leadership of the service was very good.

The registered provider was passionate and dedicated to providing an outstanding service to people. This enthusiasm had been passed onto staff and morale was high.

The registered manager was extremely visible and accessible and worked as a positive role model to staff and people at the service.

The staff team worked in partnership with other organisations at a local and national level to make sure they were following up to the minute practice and providing a high quality service.

Staff were supported to explore new opportunities for people. The management team ensured that people at the service were central in service planning.

The management team actively encouraged staff to raise concerns and challenge each other in a positive to way to promote reflective practice and best outcomes for people.

Pinewood & Hollywood

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 4th of March 2016 and was unannounced and carried out by one inspector.

Before inspecting the service, we looked at all the information that we held about the service on our systems. This included notification's that the service had sent us.

During the inspection we talked to seven people who used the service, and spoke with six relatives. We looked at five staff files to see how effectively staff had been inducted to the service, trained, and supervised. We also review four service users care records, care plans, and risk assessments.
We looked at the policies and procedures in place, and whether the provider followed this appropriately to manage and mitigate risks to people.
We talked to three health and social care professionals who had worked alongside people using the service. This included advocacy services, a nurse from the local hospice and a social worker for a person using the service. We also spoke to six members of staff and the registered manager.

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Good

Is the service safe?

Our findings

Relatives told us that people living at Pinewood and Hollywood were safe due to the competence and knowledge of the registered manager and staff in working there.

People were protected from risks of abuse. Staff at the service were all trained in safeguarding vulnerable adults and children and were able to describe in detail in the features of potential abuse. Staff had annual safeguarding updates and understood how to report concerns, and how these should be managed.

Staff spoke of the management team as being proactive and supportive. They told us they were able to report concerns without fear of discrimination, and to challenge when they felt people's safety was at risk. We observed a positive organisational culture within the two bungalows where staff felt able to challenge each other when handing over information about people using the service, in particular in relation to supporting people to achieve their potential.

People had comprehensive risk assessments. When risks were identified, these were considered against the person's hopes and dreams. 'Hopes and Dreams' document was completed with people and their families to identify their ambitions and goals.

Staff, worked with people to see how a goal could be achieved, whilst minimising the risk as far as possible by looking at innovative ways of how to support that person to achieve their goal with a positive risk taking approach. For example, a person with physical disabilities, who wished to travel on an aeroplane, would be supported to spend a day at a specialist aeroplane rig to see if they could mobilise in and out of an aeroplane seat. A comprehensive risk plan was completed to mitigate, and manage potential risks. This included photographs of people using the equipment with specially trained cabin crew staff and care staff, forming part of a risk management manual handling plan for care staff to follow.

Staff discussed changes in people's needs in daily handovers and weekly meetings. Keyworkers would then update care plans, and risks assessments if this were needed taking into consideration people's wishes. Discussions would focus on how to meet needs in the least restrictive way, whilst maintaining safety.

If a person displayed increased agitated behaviour that challenged, staff tried to identify the cause of the distress. One member of staff told us, "If people start to become distressed or agitated we know that something has gone wrong and they are trying to communicate this to us. It's up to us to find the cause of that distress and help the person to overcome it." Staff were able to tell us about a recent situation when they had explored many potential causes of someone's distress. Eventually they found the cause and developed a plan to minimise the distress, whilst maintaining the safety and dignity of the person.

Incidents were reported and investigated in detail and action plans were developed to minimise future risks and learn from events. For example, when someone had fallen following a seizure additional support would be sort from outside agencies, to explore if assisted technology could be utilised to minimise risks. For example, one person had installed into their bedroom listening devices, so that staff could hear when they

were having a seizure at night, and safely support them.

Staff were competent in medicines management, dispensing, monitoring, and disposing of medicines safely. Staff received medications training which was updated yearly. The registered manager carried out observations of staff dispensing medicines every three months to ensure competency. Staff told us they felt confident when administering medicines and were able to demonstrate good knowledge and kept an information folder of medications administered.

Medicine errors were infrequent and when they had occurred staff reported these quickly. Staff would then receive additional supervision, training, and observations before being able to administrator medications independently. Medications were stored safely. The registered manager told us that during the previous hot summer the service had taken extra measures to ensure that medications remained stored at the correct temperatures. This included fitting a fan in the room where medication was stored. When the temperature was too high, the service had contacted the pharmacy and acted appropriately. Medication Administration Records (MARS) were checked at the end of each shift and audited weekly.

People using the service had comprehensive medication care plans which were regularly updated every three months by the registered manager, or earlier if changes were made by the GP. Care plans included mental capacity assessments related to taking medications. The service had a good PRN (when necessary) medication protocol. This would include medications for pain relief. We saw that medications for agitation were rarely used due to staff having the knowledge and skills to support people when distressed.

Most staff had worked at the home for a number of years and knew the people at the service well. When staff had been unwell, regular staff would be contacted, and the shifts had been covered safely and the registered manager would be on call for urgent staffing concerns.

Staff at the service were unable to work until they had received an enhanced disclosure outlining any previous criminal convictions, and two satisfactory references. The manager ensured that any agency staff had received the same checks prior to coming to the unit and agency staff profiles were kept in the office.

The service had appropriate staffing levels. Agency staff received a thorough introduction to the service, the people living there, and fire and emergency procedures. Agency staff were always supported by senior staff on a sleep in shift.

The organisational values focused on staff supporting people at the service to achieve their full potential. The registered manager carried out comprehensive interviews based on these values with potential candidates that worked on a point scoring system. The panel would consist of the registered manager, a member of staff, and someone using the service to represent their peers. People at the service were supported to ask their own questions which had been developed through community meeting discussions so that the questions represented the people living at the service. We saw that on one occasion two candidates had scored the same during the interview. The final decision of who to employ was decided by the people using the service.

The environment was clean and safe. The service carried out comprehensive monthly health and safety checks to ensure that environment was well maintained and safe. This included individual risk assessments for people using the environment. This included risk assessments and action plans to support people in event of emergency, such as if there was a fire at the service. The service had undertaken fire drills to ensure that plans would meet people's needs. The registered manager made requests to update equipment and furnishings as needed, and the provider supported these requests.

Good

Is the service effective?

Our findings

People using the service looked happy and at ease when staff supported them in care activities. This was because staff had the skills and knowledge to provide good care, and carry out their roles and responsibilities.

New staff undertook a comprehensive induction and probationary period which involved regular observations of care, supervisions, and mandatory training. They completed both e-learning and face-to-face training.

The service had introduced the Care Certificate for new starters. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high quality care and support.

We saw that Care Certificates had been completed in depth, and that reflective practice was encouraged. Staff that had newly joined the service told us how this had supported their development, and improved their confidence to carry out their duties. One person said, "It has helped me to develop my confidence in supporting people with Learning disabilities." The registered manager was able to extend the care certificate up to six months when required, to ensure that new staff could meet all the competencies comprehensively and at their own pace.

Trainers attended the unit to carry out manual handling training, and we saw that staff were competent in using moving and handling techniques. We observed staff gaining permission to help support people, communicating to that person in the most appropriate way for that individual, what they were going to do, seeking consent at each stage.

Staff were supported to develop their knowledge and skills and this motivated them to provide a quality service. People using the provider's services were involved in developing and delivering the training to staff and called co-trainers. Working alongside existing staff, co-trainers were able to teach staff about what is important to people at the service. Whilst people at this service had not directly been involved, staff told us they could access this training.
This supported staff in developing their understanding of the importance of individualised and person centred care, with a strong emphasis on this being based around peoples preference's and strengths and how to support people to overcome barriers and promote their independence.

Some people at the service had dysphasia and the registered manager had introduced a Dsyphagia Champion who had received additional support and training. Dsyphagia. This is a condition whereby people have difficulty/discomfort in swallowing foods or liquids. They need to have their foods and liquids at a certain texture, which is all assessed by the Speech and Language team. Once they had finished their training, they shared their new knowledge with their peers during staff meetings.

As well as the Dsyphagia champion the registered manager had also introduced an epilepsy champion at the service who had received additional training and who staff could access support from. Information folders were introduced by the champions to provide information to staff about the condition and contact numbers for support.

The registered manager told us that this had supported staffs to become more knowledgeable about these conditions, which has enhanced the care provided to people with these conditions. We spoke to staff who were well informed. We observed through incident reports that this had meant staff were able to quickly and competently attend to people needs during a seizure, minimising risk of injury and emotional distress.

We observed staff communicating effortlessly with people, intuitively knowing what they wanted. We observed people smiling and laughing when staff had interpreted them correctly and knew what they wanted and needed. They were able to do this because they had received training in on how to communicate with people who did not have the ability to vocalise their needs, including Makaton and sign language.

Staff could take part in accredited programmed such as NVQ in health and social care. Staff told us that, "I know I can ask for additional training if I need it. It's all been very good." Another member of staff said, "The training is excellent, I have never worked anywhere that trains their staff so well." Relatives told us, "The staff are really well trained and know what they are doing."

All staff were trained in the MCA and DoLS (Deprivation of Liberty Safeguards). 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.

We observed that the service used creative ways to manage risk to keep people safe whilst experiencing full and meaningful lives. Staff confidently, and competently making use of the Mental Capacity Act (MCA) 2005 in a way that maximised people's potential. We saw examples of positive risk taking on the day of inspection and within people's daily notes, for example supporting people to access community services independently.

Staff knew the best times and places to support people's decision making capacity by carefully reflecting on people's presentation, what mood they were in, if they were in the best surroundings to receive information and understand it. Once decisions were made staff would then provide evidence to demonstrate how the person had been involved in making a decision and discuss this within care reviews with other professionals, including best interest assessors and advocacy services. This ensured that people experienced a very good quality of life, as the level of care and support provided promoted their wellbeing and independence.

The registered manager had ensured that appropriate Mental Capacity Assessments had taken place and regularly reviewed to minimise risks had the potential to impact on privacy and dignity, for example the use of listening devises in people's bedrooms if at risk of seizure's. We saw in people's care plans that they were involved in making the decisions around what equipment to use, which reduced anxiety over the interventions and allowed people to work collaboratively with staff. People were involved in deciding when and how the equipment would be used, such as making sure it was only turned on during the night when there was less contact with staff.

Family members of people who lacked capacity were fully involved in all aspects of decision making,

alongside staff and advocacy services. When a person lacked capacity, this did not stop staff from using a variety of communication techniques to understand their wishes. For example, when making holiday destination decisions staff would explore with people their likes and dislikes, show them pictures, talk to their loved ones and then create what the holiday would look like in special photo books that people kept. This helped people to feel in control of their holiday and prepare themselves for the change in daily routines. People wanted to show us their photo books and were evidently very proud of them.

There was an emphasis on the importance of good nutrition and hydration. There are strong links with dietetic professionals and staff were aware of people's individual preferences and patterns of eating and drinking. Individual outcomes for people were positive over time and as their health allowed.

People said that the mealtimes and food at the home were "Very nice" and that their individual needs were being met and staff went out of their way to meet their preferences. Relatives told us the food was very good and spoke highly about the quality of the food and choice available. Fresh fruit and a variety of hot and cold drinks were available throughout the day.

We observed that meals smelt and looked appetising and were freshly prepared from scratch with people at the service, promoting daily living skills. One person told us how much they loved carrot cake and they enjoyed making it with staff. They told us that they wanted to bake us a carrot cake, but they were going to town and did not have time. On return from town they had brought a cake carrot to share with us and it was evident that they felt a strong sense of self purpose and pride in doing so.

Links with health services were excellent. Health and social care professionals told us that the service was proactive in taking preventative action to enable people to maintain good or the best of health. Where people had complex/continued health needs, staff sought to improve their care, treatment and support through the implementation of best practice. For example, one social care worker said, "I felt that they worked in improving the quality of life for the [Person] and also were concerned about his health, supporting their relative to seek help for [Person's] severe epilepsy. They provided documentation and evidence of seizures for the neurologist."

When people were anxious about having physical checks done, such as having blood tests, the staff had taken measures to support them. One example of this might be talking daily to people about what would happen, using photo cards, for at least one week prior to a blood test so their anxiety levels were reduced. This had proved successful for people needing this type of reassurance.

Social care workers told us the service acted as an advocate for service users and that the registered manager constantly strives to get the best outcomes for them. A parent of a person at the service stated, "[Person] was so poorly for many years that we didn't think they would ever improve. This service has done absolute wonders in accessing the best treatment. I am so thrilled that [person] has such a wonderful place to live."

We saw evidence that people were supported to receive regular foot care from qualified professionals, dental treatment, opticians, and services such as audiology for hearing equipment. Risk assessments and Mental Capacity Assessments would be recorded relating to any medical intervention and appointments. When we spoke to staff they knew how to access dietician and other health professionals and had in the past sort support from these professionals, including accessing speech and language therapists.

The service had good systems for recording and communicating appointment times and there was always sufficient staffing to ensure that access to these services could take place, for example, additional staff could

be requested to facilitate appointments.

People received timely intervention from a variety of other health professionals. Because people's health needs were so comprehensively looked after meant they were able to be more active and achieve a greater level of independence and engagement with the world around them, including being able to access the community.

People at the service were supported to be involved in all decorating of the home. Bedrooms were individualised, well maintained, homely, and warm. Pictures of people's loved ones were displayed in a considered manner and people had their names and photos on their bedroom doors. These were also individually decorated.

People had chosen the colours they wanted for carpets, wall paints, calendars, and bedding. The communal areas were warm, comfortable, light, and homely. The service had considered all people needs and preferences in furnishings.

Staff had painted murals of people's favourite things on the walls when people had wanted this. Memories of their favourite hobbies and holidays were carefully framed, and displayed, demonstrating a high level of respect for the person. Three people at the service insisted that we see their bedrooms. People at the service indicated to us that they wanted to show us their bedrooms. It was clear from observations and our interactions that people were immensely proud of these spaces. We asked one person what they thought of their bedroom and they told us, "It's wonderful!" rooms. The involvement of people and the careful attention to detail meant that people experienced a level of care and support which was meaningful and supported their wellbeing.

Good

Is the service caring?

Our findings

We observed that people and staff had mutual positive regard for each other. People would casually laugh and joke about everyday things, such as something on the television, an outing or when recalling something funny.

The service had a strong, visible, person centred culture. One relatives told us, "Staff often go the extra mile for people there," We saw that staff often supported people in their own time to access activities, not out of service need or lack of staff, but rather to enhance people's lives as an act of friendship. If staff had a day off and the service had a gathering, such as a BBQ, staff would come in as they would to a family event.

People and family members, friends/advocates were actively involved in the running of the service. Relatives told us, "Staff are brilliant, they always ask my opinion and tell me when things have happened. I have complete faith in the staff and always feel involved." Another person said, "I really enjoy the get-togethers they put on. It is great to get to know the other parents and relatives. It feels like a family." One social care professional told us, "[Person's] relative was very happy with the home and felt comfortable to visit and obviously had a good rapport with staff."

There was a strong sense of family and positive mutual regard across the service that was meant that people living at the home were cared for to the highest level. One relative echoed this telling us, "Because of this, people felt really cared for." Another relative said, "[Person] absolutely loves it there," and, "Staff are ever so caring it is a wonderful place."

We observed interactions and saw that relationships between staff and people using the service were extremely positive, compassionate, and caring. Staff involved people fully involved people in all interactions which made of an inclusive environment. People valued their relationships with the staff team.

Staff were committed to working in partnership with people in imaginative ways, which meant people felt consulted, empowered, listened to and valued. Using the information they already had about the person, staff spent time with them exploring books, the internet and local community links, such as the adult learning centre, for potential activities that might bring peoples individual hopes to fruition. One person had enjoyed making pottery and consequently the service had accessed a pottery class for them which they successfully completed.

Staff displayed determination and creativity in helping people overcome their disabilities to achieving personal goals. We saw examples of this in care notes and care plans and people showed us scrap books with photos of their achievement's, from holidays to outing's. They were extremely proud to show us these.

Staffs knew, understood and responded to each person's diverse cultural, gender and spiritual needs and meet their needs in a caring and compassionate way. We saw examples of people's interests had been encouraged and strengthened by accessing varied and interesting activities. This included considering all potential risks of any new environment, and investigating the appropriateness of the activity. We saw that

assessments were managed very sensitively to that person's needs. This enhanced people's quality of life. A member of staff speaking to a person asked them if they were excited about an event they were attending that evening, the person was able to demonstrate that they couldn't wait through sign language.

We saw strong evidence in people's care plans that people's sexuality was respected. Care plans were sensitive to people's individual needs with a strong emphasis on staff supporting people's privacy and dignity. For example, the manager had accessed support for people from a specialist therapist for people with LD who had provided a series of sessions on sexuality and keeping themselves safe. The tools and interventions were incorporated into the care plan to manage risk of the person becoming vulnerable.

Staff reflected on the physical and emotional impact of activities on people, for example if they would tire them out. They offered people choice about what they would like to do after activities, such as rest or simple low level activities. These things were tailored to be flexible and adapt to that individuals needs and preferences. This empowered people at the service and supported them to develop a strong sense of self-worth.

We observed through interactions that people using the service felt able to approach staff with ease. Staff were warm and friendly in responses to people and if people were seated, they would get down on the same level to interact. Staff would spoke to people in a respectful manner and when people wanted something but were unable to vocalise this, we saw that staff intuitively understood what they needed by carefully listening to them and asking them questions and using sign language and gestures. We observed people delighted in the interactions from staff through their smiles, and reaching out to staff.

Staff used therapeutic touch in an appropriate manner to offer comfort and support, and people using the service returned this. We saw one person walk behind a member of staff and hug them. The member of staff said, "Thank you [Person], that's lovely." The person was thrilled with the response. One relative told us, "It is like a loving family there. The staff are incredibly caring and considerate. I am so glad that [Person] is there. I know that they are receiving the best possible care and attention."

Staff respected people's confidentiality and did not speak about other service users' personal needs openly. Staff had a very good understanding of people's rights to dignity and privacy, and worked hard to ensure that this was protected by looking at how a person could be supported to be as independent as possible.

Staff reflected on practice and encouraged new starters to challenge themselves as to why they did certain things for people and to consider how they could support, "Staff taught me about how important it is that people be given the opportunity and support to be as independent as possible and how we need to find ways to maximise their potential."

When people had been bereaved, the service had identified that some changes in their behaviour were potentially caused by grief. They had made efforts to contact bereavement services and specialist bereavement therapy was found. This had a positive impact on people. Once the bereavement therapy had finished, staff had been equipped with the knowledge to identify grief and how to support people. They had also been able to re-refer the people for additional support due to the links they had built up.

We saw evidence that the service had cared for people with end of life care needs, in sensitive and creative way that enabled people to remain in their home, surrounded by familiar faces and those they had developed strong relationships with. During which time they worked in closely with the local Hospice and other health professionals. Professionals told us, "The registered manager and staff are very good. They are very caring to people's needs and determined to support them to remain at home if they want too… I am

not sure anyone else could have managed [Persons] needs, as they were. It was not an easy situation, they did incredibly well."

Good

Is the service responsive?

Our findings

People at the service had a variety of individualised care plans that addressed their needs in a person centred way. Care plans focused on how staff could support people to achieve their full potential and were written in easy read format. We saw that people had signed their care plans and when they had been unable to, capacity assessments would be carried out. Where appropriate relatives would review and sign them.

Regular care reviews took place with service users, relatives and health and social care professionals. Relatives told us, "Yes they regularly review [person's] care and I am always invited to the reviews. Their focus is about helping [person] achieve their potential and how to make that happen."

The service advocated for people in their care and ensured they received the appropriate additional support. One social care professional told us, "I would have no hesitation in placing other people there, including my own relative." One social professional told us, "They were expecting me, planned for my visit, and got all appropriate people at the meeting, and involved the person who care is provided for. They had excellent recording procedures. Staff knew the [Person] well and advocated for them."

Care and support is planned with people's involvement. We saw that when there was a need to carry out physical care interventions that this was considered in a sensitive way and appropriate care plans developed for people. For example, choosing whether a female or male care worker would support a person with personal care needs, such as washing and dressing.

People were encouraged and supported to engage with a variety services and events outside of their home to enhance their quality of life. This included a variety of learning opportunities such as skills enhancing courses to promote creatively and well-being. People at the service received regular brochures from the adult learning centre. Their key workers would spend time with them exploring potential courses and whether they wanted to take part. Once a class had been identified, people would be supported to attend.

Meaningful and enjoyable activities such as swimming, bowling, Ice skating and horse riding enhanced people's lives. Staff also ensured that people could experience fun social activities such as eating out in restaurants, visiting the zoo and safari parks.

The enthusiasm of people at the service and staff was evident and this spurred staff on to continue to encourage engaging and meaningful activities. It was evident in interactions and demeanour's that people at the service were proud of their achievements. One relative told us, "My [person] is so happy there; they do so much for [person]. [Person] is never bored and [Person] loves all the staff. [Person] is always doing something."

The service held regular community meetings and people were supported to make decisions about the service and express their views through a variety of communication techniques suited to each person's level of ability. People had regular holidays, which they chose through time spent with their key workers. Holidays that had taken place included trips abroad to theme parks, swimming with dolphins and adventure

holidays. People did not go on holiday at the same time, but would go with people in the service that they had formed friendships with. This included people from other residential settings run by the provider. This meant that holidays were individualised.

We saw detailed holiday plans and risk assessments. Staff took photographs of specialist equipment that they would use to support people to access various activities. This included plans for where equipment could be hired. We saw a photo of a person in a specially adapted wheelchair that allowed them to go on the sand. Staff who knew people well would support them on holiday. Photographs and people's reactions to holiday discussions demonstrated that staff ensured that holidays were about the person. In staff interviews, staff told us people's achievements made them feel proud of the work that they did.

Easy read posters were displayed on the walls to how people could complain and raise concerns. Family members were encouraged to provide feedback to the service. Most family members were actively involved in people's lives and told us that they felt able to complain and raise concerns and knew how to do so. They spoke of the registered manager and staff being open and transparent. One person said, "The registered manager is open to concerns and responds quickly. They always keep us updated on changes to the service." We saw only one complaint about the service from a relative, but this had been resolved and the relative had withdrawn the complaint. The service always investigated people's concerns and acted upon these.

Good

Is the service well-led?

Our findings

The service promoted a positive culture that was person-centred, open, inclusive, and empowering, because it placed peoples individual needs, preferences and choices at the centre of care provision.

The registered manager had a clear vision of how the service should be run to the benefit of the people residing in it, and staff at the service shared this vision. Staff had an excellent rapport with their colleagues. We observed handovers where staff openly questioned each other and discussed how to best meet people's needs. People at the service were central to all risk and care planning activities and these were regularly reviewed.

Values firmly centred on the fact that people at the service could achieve their dreams if the right support was in put into place and that staff and people would work together to find that that support and overcome barriers. This was reflected in the care plan interventions and in daily entries that documented what people did in their daily lives and was evident within interactions between staff and people on the day of inspection.

The registered manager was keen to investigate new avenues of support and innovative ideas to make people's hopes and dreams a reality. For example, some people had dreamed of swimming with dolphins and the service had made this happen.

When activities were threatened due to circumstances outside the home, staff actively advocated for people. For example, one social care worker told us, "The registered manager constantly badgered me to come to meetings and get access for [Person] for the day centre, when the day centre had been concerned that they wouldn't manage [Person] needs. The person did get access and this improved their quality of life."

The manager kept up to date with changes and developments of a variety of health conditions that people experienced at the service by constantly reviewing new clinical evidence and treatments through online journals, recommendations by the department of health for best practice and associated societies for various conditions. For example, best practice for managing the needs of people with epilepsy and autism. They ensured systems were in place to make this information assessable to staff through regular staff meetings and time to just sit and read the information. The knowledge that staff had was evident in care notes, interviews and interactions with people which meant people needs were met quickly and in line with best practice.

Staff were encouraged to review existing practices during meetings and see if improvements could made. Consequently staff had sound knowledge about why individual's care plan interventions were needed and because of this they provided people with consistently effective care.

The registered manager was a visible, hands-on, effective role model, actively seeking and acting on the views of others through everyday engagement, reviews, and community meetings. They had developed and

sustained a positive culture in the service, encouraging staff and people to raise issues of concern with them. A member of staff told us, "I feel able to approach the registered manager about any concerns. She listens, takes things on board and when action is needed takes it." We saw evidence that when staff had raised concerns these were investigated, and addressed. Staff felt they could approach the manager with new ideas, for example activities in the community and allowed staff to present their ideas to people at the service.

The registered manager worked proactively to ensure they were following best practice. They attended regular management meetings with other managers across the organisation and shared best practice. They strove for excellence through consultation with other health and social care professionals, and encouraged reflective practice in team meetings.

Team meetings resulted in changes to the service, such as improving the key working system, which freed staff up to give more time to people. One team meeting identified that some people had high level of anxiety, wanting to know what staff would be coming on duty. Consequently, the registered manager introduced of a photo board rota of staff so that people could see at a glance who would be caring for them. Staff told us this had reduced people's level of anxiety considerably.

Best practice examples included finding and accessing assistive technology to minimise risks, whilst promoting privacy and dignity, for example when someone was at high risk of epileptic seizures during the night, staff had considered a variety of options with that person as how to keep them safe. The person did not want to have a camera in their bedroom or to have staff constantly peering around their bedroom door. So between the person, and staff team, it was agreed that the person would have a listening monitor in their bedroom for night hours only. Staff on duty made sure that during the day these were turned off.

The service collected evidence of new guidance and treatments when working with other health and social care professionals in order to get the best possible outcomes for people at the service. Because staff were informed they were able to access the best possible care for people. A social care worker told us, "The service dedication to find and source the best outcomes was good. I found the service over all to be outstanding."

The registered manager and staff at the service had excellent relationships with people's relatives, and where appropriate relatives were involved as far as possible in their loved ones care planning. The registered manager had introduced stakeholder questionnaires sent out to all people involved with the service and responses were actioned and addressed. This included redesigning of the garden area to make it more user friendly.

Following a concern from a relative that they had spoken to staff and information had not been handed on, the registered manager developed a 'Record of Conversation Form.' This meant the registered manager could look back at any time to see the conversation and respond appropriately and staff had a record to handover to each other so important information would not be missed, This meant the registered manager had a good understanding of what was happening in the service and would be able to address any concerns that relatives had quickly, a alongside identifying any learning points for staff.

Staff told us that morale was high. All staff we spoke with told us that they enjoyed working with at the service and loved their jobs. One person said, "It's the best job, I love working here. I love the people. We are like a family." Another member of staff said, "It's a brilliant job, I wouldn't change a thing."

Staff stayed at the service a long time. When staff left, it was generally because they had gained professional

qualifications such as becoming occupational therapists or Speech and Language therapists. The registered manager recognised the benefit of retaining staff on flexible contracts whilst they trained in their own time to achieve professional qualifications. The registered manager told us that whilst they would eventually lose a member of staff, the skills and knowledge they gained through training benefited the remaining staff and consequently the people using the service.

The service had clear levels of responsibility and leadership and staff were supervised accordingly. A social care professional told us, "The manager runs a tight ship. The service is very well run." Staff worked collaboratively, regardless of level of seniority, and were encouraged to express their ideas and views.

Senior staff were approachable and available. They took part in shift work and role modelled the expected behaviour they expected from junior colleagues. They also completed clinical audits and were given administration days to complete these and any other paperwork. This meant that these tasks would not detract from the time given to people at the service.

The registered manager competently and proactively met their roles and responsibilities and sent in the correct notifications to the relevant agencies.

There was a clear development plan for the following financial year and the manager carefully managed the budgets available to ensure that people's needs were met. When additional resources were needed, For example, obtaining a new specialist bath, the registered manager put forward proposals and plans to gain extra funds.
People and staff at the service were involved in all decision making and planning and these were discussed in community meetings and staff meetings. The manager consulted people at the service when they needed to fund a new community bus. We saw evidence that the need for a new bus had been carefully explored. The registered manager had looked at safety, practicality and cost. When people at the service needed to provide a financial contribution, we saw that there had been a comprehensive consultation. People had capacity and best interest assessments to ascertain if they understood, with the involvement of people's power of attorney and support from advocacy services where required. The manager had been creative in creating photos and examples of transport in easy read format where people could chose the transport they liked. We saw that the transport remained at the service at all times, and was regularly used for outings and attending appointments.

The service had robust governance procedures in place that were well organised and easily accessible. Audits were kept for cleaning, medication, equipment and the general environment. Incidents were reported and investigated and we saw that when required improvements were identified these were implemented.

The registered manager carried out audits that monitored how peoples' dignity and privacy was being managed and used the information to make improvements to the service. These audits had demonstrated the need for staff to have one-page profiles. This was set out as easy to read and told people at the service and their relatives about the staff caring for them. For example, staff likes and hobbies, sharing similar interests with people at the service. This enhanced the relationships with people, and staff were happy to share this information.

This was a service that continuously learnt and strived to make improvements through open dialogues with staff and people at the service and exploration of new ideas and practices.