Aitch Care Homes (London) Limited

Byfield Court

Inspection report

Byfield Court
Sheppey Way, Bobbing
Sittingbourne
Kent
ME9 8PJ

Date of inspection visit:
23 August 2016

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07 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on the 23 August 2016 and was unannounced.

Byfield Court is one of several small homes owned by Aitch Care Homes (London) Limited. Byfield Court provides care and accommodation for up to eleven people who have learning difficulties. The service aims to work with young and older people with autistic tendencies supporting them to gain greater independent living skills. There were eleven people living in the service when we inspected. Seven people left shortly after the start of the inspection to go out on a planned visit to a rare breed centre.

We last inspected the service on 12 January 2016. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to Regulation 17, Good governance and Regulation 18, Staffing. Following the inspection the provider sent us an action plan to show how they intended to improve the service and meet the requirements of the regulations. At this inspection we found that the provider had implemented their action plan and improvements had been made.

There was a registered manager employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The registered manager was not available on the day of the inspection, and the deputy manager assisted with the inspection process.

People were protected against the risk of abuse. We observed that people were safe in the home. Staff had received training about recognising the signs of abuse or neglect and knew what to look out for. Both the registered manager and staff understood their role and responsibilities to report any concerns and were confident in doing so.

The home had risk assessments in place to identify and reduce risks that may be involved when meeting people's needs. There were risk assessments related to people's behaviour and details of how the risks could be reduced. This enabled the staff to take immediate action to minimise or prevent harm to people.

There were sufficient numbers of suitable staff to meet people's needs and promote people's safety. Staff were aware of their roles and responsibilities and the lines of accountability within the home.

Staff were recruited using procedures designed to protect people from unsuitable staff. Staff were trained to meet people's needs and had received training relevant to their roles.

The systems for the management of medicines were followed by staff and we found that people received their medicines safely. People had good access to health and social care professionals when required.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Management understood when an application should be made. They were aware of the Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff had developed positive relationships with the people who used the service. Staff were kind and respectful; we saw that they were aware of how to respect people's privacy and dignity. People told us that they made their own choices and decisions, which were respected by staff.

People were involved in assessment and care planning processes. Their support needs, likes and lifestyle preferences had been carefully considered and were reflected within the care and support plans available.

Health action plans were in place and people had their physical health needs regularly monitored. Regular reviews were held and people were supported to attend appointments with various health and social care professionals, to ensure they received treatment and support as required.

Staff meetings took place on a regular basis. Minutes were taken and any actions required were recorded and acted on. People's feedback was sought and used to improve their care. People knew how to make a complaint. Complaints were managed in accordance with the provider's complaints policy.

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.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

The provider operated safe recruitment procedures and there were enough staff to meet people's needs.

Appropriate systems were in place for the management and administration of medicines.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills required to meet people's needs and promote people's health and wellbeing. One to one supervisions and appraisals had regularly been undertaken.

Staff understood the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards, which they put into practice.

People were supported to have enough to eat and drink.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were supported by staff in a way that respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and staff.

People were treated with respect and helped to maintain their independence. People actively made decisions about their care.

Is the service responsive?

Good

The service was responsive.

People had been involved in a wide range of everyday activities. Activities had been carried out based on people's plans.

People's needs were assessed and care plans were produced identifying how support needed to be provided. These plans were tailored to meet each individual's requirement and reviewed on a regular basis.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The provider encouraged an open and approachable management system. Staff told us that the registered manager was approachable. Staff were supported to work in a transparent and supportive culture.

There was an effective quality assurance processes in place to monitor the service to enable people to receive a good quality service.

Staff were clear about their roles and responsibilities.

Byfield Court

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 checked 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 23 August 2016, was unannounced and carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We took all of this information into account when planning the inspection.

We observed people's care and support in communal areas throughout our visit, to help us to understand people's experiences. We looked at the provider's records. These included two people's care records, care plans, health action plans, medication records, risk assessments and daily notes. We looked at three staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside spaces available to people.

We observed people who were unable to verbally communicate with us. We spoke with two support workers, one senior support worker, the deputy manager and the locality manager who visited the home during our inspection. We contacted three relatives of people who received support. We also contacted health and social care professionals who provided health and social care services to people.

Good

Is the service safe?

Our findings

People we spoke with showed us through facial expressions and body language that they liked living in the service and felt safe. We observed that people were relaxed around the staff and staff interacted well with people.

Relatives commented, 'I feel very comfortable that my son is safe', and 'I would say the service is safe'. A health and social care professional commented, 'I feel that in my experience for the people I have with Byfield Court, I feel that the service meets my client's needs in a caring and responsive way'.

Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area. It provides guidance to staff and to managers about their responsibilities for reporting abuse. These policies clearly detailed the information and action staff should take, which was in line with expectations. Staff told us that they had received safeguarding training during their induction. Training records evidenced that all staff had completed safeguarding training within the last two years. Staff were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions that may occur. A member of staff told us that if she was unable to discuss a concern with the registered manager, she would contact Social Services or the Care Quality Commission. Staff told us the registered manager would respond appropriately to any concerns. A Safeguarding protocol was visibly displayed on notice boards in the service for staff. The organisational safeguarding and whistleblowing policies in place were up to date and reviewed regularly. We saw that these policies clearly detailed the information and action staff should take. This meant that effective procedures were in place to keep people safe from abuse and mistreatment.

Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. They said, "I will have no hesitation in whistleblowing. It tells us we have a voice in raising issues. I can contact local safeguarding and CQC if required", and "When you see something you believe is wrong, you can inform external agencies".

Within people's support plans we found risk assessments to promote and protect people's safety in a positive way. These included; accessing the community, finances, medication administration, fire, domestic skills/daily living skills, activities and personal care. These had been developed with input from the individual, family and professionals where required, and explained what the risk was and what to do to protect the individual from harm. We saw they had been reviewed regularly and when circumstances had changed. Staff told us they were aware of people's risk assessments and guidelines in place to support people in line with their assessed needs.

Records showed that incidents and accidents were monitored in order to ensure that preventative measures were put in place if required. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These records were shown to us as part of monitoring system. The deputy manager said, "We document all

incidents using the ABC (Antecedent, Behaviour and Consequences) form, report it to the registered manager who will go through and also report it to higher management if need be". Records showed these incidents were clearly reviewed and any actions were followed up and support plans adjusted accordingly.

We observed that there was sufficient numbers of staff to meet people's needs. Through our observations and discussions with people and staff members, there were enough staff with the right experience and training to meet the needs of the people who used the service. The staff rotas and training files supported this.

The provider had an up to date recruitment policy in place, which enabled safe recruitment procedures to be followed. The recruitment files contained all of the information required under Schedule 3, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. This meant people could be confident that they were cared for by staff who were safe to work with them.

A medicine policy was in place to guide staff from the point of ordering, administering, storing and disposal of any unwanted medicines. Medicines were booked in by staff and this was done consistently with the medicine policies. There was a system of regular audit checks of medication administration records and regular checks of stock during staff handover. There was a system to promptly identify medicine errors and ensure that people received their medicines as prescribed. Medicines were stored appropriately in a locked cabinet and all medicines records were completed correctly.

Staff who administered medicines were given training. Staff had a good understanding of the medicines systems in place. Temperatures of all medicines storage was checked and recorded daily, and these records were up to date. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. The records showed that people had received their medicines as prescribed.

Maintenance checks and servicing were regularly carried out to ensure the equipment was safe. Risk assessments for the building were carried out and for each separate room to check the premises was safe. Internal checks of fire safety systems were made regularly and recorded. Fire detection and alarm systems were regularly maintained. Staff knew how to protect people in the event of fire as they had undertaken fire training and took part in practice fire drills. Risk assessments of the environment were reviewed and plans were in place for emergency situations.

There was a plan staff would use in the event of an emergency. This included an out of office hour's policy and arrangements for people which was clearly displayed in care folders. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. Staff had the knowledge and skills to deal with all foreseeable emergencies.

Good

Is the service effective?

Our findings

Not everyone was able to verbally describe their experiences. We observed that people had the freedom to move around the service and spend time alone in their rooms as well as in communal areas. People were relaxed. We observed staff members responding to people's needs in a timely and responsive manner.

Relatives commented, 'Very effective in providing my son with the correct provision', and 'I am very happy with the care which is provided by the staff at Byfield Court. She is very settled and has genuine affection to members of the care team and will approach them in her own way to guide them to what she wants'.

Health and social care professionals commented, 'The service has been very effective in meeting his needs and he has been stable and appears happy and settled whenever I have visited' and 'The service ensures that his mental health needs are monitored and supports him to attend all his appointments'.

Staff had received induction training, which provided them with essential information about their duties and job roles. The deputy manager told us that any new staff would normally shadow experienced staff, and not work on their own until assessed as competent to do so.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people with learning disabilities. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received regular training in a variety of topics, which included health and safety, fire safety, safeguarding, Mental Capacity Act 2005, equality and diversity, and diet and nutrition. This meant that staff received adequate training to meet people's needs.

At the last inspection, it was found that staff had not received appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. At this inspection we found that formal supervision and appraisals improvements had been made. One to one formal supervisions and annual appraisals had been undertaken on a regular basis and staff spoken with and records seen supported this. Members of staff felt supported by each other and the management team.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. 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. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. Staff could all describe how and why capacity was assessed, the statutory principles underpinning the MCA and related this to people that we were subject to DoLS.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People had access to nutritious food that met their needs. One person said, "I like it here I do, they do nice food". We saw that one person was making a drink and toast for their breakfast. There was choices of different meals at dinner time and could ask for another option if they wished. On the wall in the kitchen, there were several pictures of the day's meals for those with special dietary needs; each picture had a person's name on it and their specific dietary requirement was written on each named picture. Some people were supported to make their own meals when they wanted them. Records showed that staff supported the person to do so. People's individual dietary needs were catered for. One person's record indicated that they should have a 'gluten-free diet'. A gluten-free diet is a diet that excludes the protein gluten. Gluten is found in grains such as wheat, barley, and rye. Staff ensured that this person's food was stored separately in a cupboard. This showed that individual dietary needs were being met in the home.

The food stores were well stocked and included a variety of fresh fruit and vegetables. Food was prepared in a suitably hygienic environment and we saw that good practice was followed in relation to the safe preparation of food. Food was appropriately stored and staff were aware of good food hygiene practices. People's weight were regularly monitored to identify any weight gain or loss that could indicate a health concern.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. People had a health action plan in place. This outlined specific health needs and how they should be managed. People received effective, timely and responsive medical treatment when their health needs changed.

Records confirmed that staff encouraged people to have regular health checks and where appropriate staff accompanied people to appointments. People were regularly seen by their treating team. Some people living at the home had epilepsy and there were appropriate protocols in place concerning the administration of emergency medicines if a person had a prolonged seizure. These had been developed with an epilepsy nurse who had provided suitable expert guidance. Measures had been taken to reduce the risk of injury such as the use of mats placed besides people's beds in case they fell out during a seizure. Staff had also received specific training about how to manage seizures and how to support people with epilepsy. This meant that people's health needs in relation to their epilepsy were being monitored and managed. Health appointments were documented in people's care plans and there was evidence that the home worked closely with health and social care professionals to maintain and improve people's health and well-being.

Good

Is the service caring?

Our findings

We observed that staff were kind, considerate and aware of people's individual communication needs. There was a calm and friendly atmosphere. People's bedrooms were decorated to their own tastes.

Relatives commented, 'Very caring, one of the main reasons that my son is so happy', and 'The staff are very caring towards her. I can tell this by the way she interacts with staff'. Health and social care professionals commented, 'My observations of the care during a recent visit was positive. All staff observed appeared to be very attentive and warm to the service users', and 'Her room was well presented, comfortable to her taste'.

People's personal histories were detailed in their care files which enabled new staff to know and understand people and their past. Staff knew the people they were supporting very well. They had good insight into people's interests and preferences and supported them to pursue these. Staff spoken with were able to talk about the person's preferences about privacy and how they respected them. This showed that staff supported people based on their involvement, choice and preference.

Interactions between people and staff were positive and caring. People responded well to staff and engaged with them in activities such as writing, arts and craft and colouring. People approached and spoke to each member of staff with ease.

People and their relatives had been involved with planning their own care. There was evidence of this within care plans, and through photographs. Where people had made decisions about their lives these had been respected. For example, the care plan included a section for 'Things that I would like you to know about me'. 'My communication', information stated that the person engages in conversation and can make their needs known. 'What I am good at', included woodwork and swimming. 'The main areas I need support in', these were detailed as personal care, daily living skills, activities, diet, medication, health, mobility, finances, social and mental.

People were involved in regular review of their needs and decisions about their care and support. This was clearly demonstrated within people's care records and support planning documents that were signed by people. Support plans were personalised and showed people's preferences had been taken into account.

The management and staff showed genuine concern for people's wellbeing. Staff worked in a variety of ways to ensure people received the support they needed. We observed staff and people engaged in general conversation and having fun. From our discussions with people and observations we found that there was a very relaxed atmosphere and staff were caring.

People and staff told us there were no restrictions on visitors. People had relatives that visited the home and others made regular visits to their relative's homes. Relatives were also invited to attend parties at the service.

Management told us that advocacy information was available for people and their relatives if they needed to

be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Advocacy information was on the notice board for people in the home.

Good

Is the service responsive?

Our findings

We observed that people were supported to access activities in the local community. Staff listened to what people wanted and picked up on signs that people wanted to go out such as key words and actions. People's care needs were kept under review and changes were made to improve their experience of the service.

Relatives commented, 'Very responsive and approachable', and 'The service is responsive. I can see that the staff get on well with each other which I believes helps in the atmosphere in the home'.

Health and social care professional commented, 'There was staff interacting with them and activities being undertaken in the sensory room and service users responses were appropriate', 'They have produced support plans which take into account all his needs and they address any concerns with me when they arise', and 'Overall, records indicate that the service user has made good progress since being placed here and has reduced her anxiety behaviours and steadily increasing her activities following guidelines. Feed back from advocate involved has also been positive'.

Care records contained people's assessments, care preferences and care reviews. Staff understood people's needs and people confirmed that they received their care in accordance with their preferences. Care records evidenced that each person had a very detailed assessment, which highlighted their needs. The assessment could be seen to have led to a range of support plans being developed. We found from our discussions with staff and individuals these met their needs. We observed that people were involved in making decisions about their care and support and developing their support plans.

Care plans provided detailed information for staff on how to deliver people's care and support in line with their assessed needs. The files were well-organised, containing current and useful information about people. Care records were person-centred, meeting people's needs and preferences were central to the care and support plans. For example, 'I am able to do my own personal care, but will needs lots of verbal prompting from staff'. Records included information about people's social backgrounds and relationships important to them. They also included people's individual characteristics, likes and dislikes and places and activities they valued. Care plans and health information was provided in pictorial format. Care plans were typed in a large font and had pictures to make the sections easily understandable.

Management told us that they planned people's activities according to their ability and preferences to ensure people were given the best opportunity to participate. Since the last inspection improvements had been made in relation to the range of activities that people were able to take part in. In one care plan it was recorded that the person enjoyed swimming, bowling and eating out, it went on to say that, 'I need 1-1 support when out in the community and for doing house activities'. Staff supported people with their individual activity plan and activities included going for a walk, going to the pub, cooking, arts and crafts and pamper session. There was a sensory room where people were able to go and relax.

People received personalised care that was flexible and responsive to their needs. For example, staff had

worked with one person's Care Programme Approach (CPA) specialists to ensure the support they provided to this person continued to reflect their changing needs. The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.

The provider contacted other services that might be able to support them with meeting people's health needs. This included the local authority's community learning disabilities team and the speech and language therapist (SALT) team. This demonstrated the provider promoted people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

People had regular one to one sessions with their key worker to discuss their care and how the person feels about the home. A keyworker is someone who co-ordinates all aspects of a person's care at the home. These sessions were documented in the person's support plan and agreed by them. Therefore, people were given appropriate information about their support at the home, and were given an opportunity to discuss and make changes to their support plans. People knew who their key worker was and proudly told us their name.

Specific communication methods were used by staff. For example, a person who did not talk communicated with their hands. This was recorded in their communication care plan and staff were aware of what each gesture meant to say. Staff were able to interpret people's body language and conversed at times with people without words, using eye contact, pointing, nodding, and mirroring their body language. People were given time to express themselves. Encouragement was provided and we observed staff and people laughing together in mutual comprehension when people were unable to talk. People had 'communication passports' when needed. These passports contained information to explain the most effective methods to communicate with people. People's voice could be heard effectively.

The provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display on the notice board of the home and this was also available in an easy read format to support the communication needs of people. This procedure told people how to make a complaint and the timescales in which they could expect a response. There was also information and contact details for other organisations such as the commission, local authorities and local government ombudsman, that people could complain to if they are unhappy with the outcome. Complaints were recorded in a complaints log. There had been no formal complaints since our last visit.

Good

Is the service well-led?

Our findings

People clearly knew the registered manager and the staff team. We observed people interacting positively with management and staff. A relative commented, 'I believe so it always seems well run and organised'. One health and social professional commented, 'Thus far, I have found the management to be very cooperative and accommodating in my requests'.

The management team encouraged a culture of openness and transparency. Part of their values included 'Compassionate Care; We listen and respond with respect and show dignity to everyone that we support; this enables us to shape services that are person centred and which promote independence, empowerment and citizenship and include the use of 'positive behaviour support' for people whose behaviour can challenge.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

At the last inspection, we found that the provider had failed to operate an effective quality assurance system and failed to maintain accurate records. At this inspection we found that the provider had maintained accurate records and improved the auditing systems. There were systems in place to review the quality of all aspects of the service. Monthly and weekly audits were carried out to monitor areas such as infection control, health and safety, accidents and incidents, and care planning. We saw evidence of a health and safety audit dated 1 March 2016 and a quality audit dated 10 June 2016 both carried out by the locality manager. The registered manager confirmed by telephone that actions had been taken to address a couple of areas that had been found to be non-compliant. There were effective systems in place to manage risks to people's safety and welfare in the environment. The provider contracted with specialists companies to check the safety of equipment and installations such as gas, electrical systems, hoists and the adapted baths to make sure people were protected from harm.

People were routinely listened to and their comments acted upon. Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. There were systems in place to receive people's feedback about the service. The provider sought people's views by using 'Questionnaires' in picture format. The questionnaires showed that people were generally happy with the service provided. Recently completed relative surveys included the following comments, ' I am happy with the care my relative is getting', I strongly believe that X(the person) is very happy at the care home and I am confident in the staff's care towards him. I am also very happy with staff's willingness to inform me of issues around his welfare', and 'My brother appears to be very happy and content at Byfield Court. It would soon become apparent to all if this were not the case'.

Management was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team when necessary. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within

the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider told us that they had accreditation schemes with Skills for Care's National Minimum Data Set for Social Care (NMDS-SC), which is an online database which holds data on the adult social care workforce. The provider used this system to update information on staff training regularly. This helps authorities to plan resources for the local workforce and commissioning services.

The provider, registered manager and staff worked well with other agencies and services to make sure people received their care in a joined up way. We found that the provider was a certificated gold member of the British Institute of Learning Disabilities (BILD). This organisation stands up for people with learning disabilities to be valued equally, participate fully in their communities and be treated with dignity and respect. The registered manager told us that being a member of BILD has enabled them to be up to date in their skills and knowledge of how to support, promote and improve people's quality of life through raising standards of care and support in the home.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

The registered manager was kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest level so that they were dealt with to people's satisfaction.

Staff had access to the records they needed to care for people. They completed accurate records of the care delivered each day and ensured that records were stored securely. People knew they could see their care plan if they wished to.