Pharos Care Limited

Katherine House

Inspection report

91-93 Sutton Road
Erdington
Birmingham
West Midlands
B23 5XA

Tel: 01217069902

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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

This inspection took place on 5 and 8 January 2018 and was unannounced. At our last inspection of the service on 6 October 2015, the service was rated as 'Good' in all questions asked.

Katherine House is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Katherine House accommodates nine people in one adapted building. On the day of the inspection, the service was providing care and support for nine people who have a learning disability and behaviours that challenge others.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who had received training in how to recognise signs of abuse and were aware of what actions they should take should they suspect someone was a risk of harm. Staff were aware of the individual risks to people and how to best to support them and manage those risks.

Staff were safely recruited and systems were in place to ensure the skill mix on each shift was able to meet the needs of the people being supported. Systems were in place to ensure people received their medicines as prescribed by their GP and staff competencies in this area were checked.

Systems were in place to protect people from the spread of infection. Where accidents and incidents took place, they were investigated and where appropriate lessons were learnt and actions taken.

People's care, health and social well-being were part of a pre-assessment process that provided staff with the information required to meet their needs effectively. Staff were provided with an induction and regular training to ensure they had the skills and knowledge to support people. Systems were in place to monitor staff learning and to ensure that training provided, was put into practice.

People were supported to maintain good health and access a variety of healthcare services. Choices were routinely available at mealtimes and picture cards were in place to assist people in making those choices.

Staff routinely obtained people's consent prior to offering support. 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 the service supported this practice.

Staff were described as kind and caring and were respectful in their dealings with people. People communicated with staff in a variety of ways and systems were in place to ensure information was available to people in a format that they understood.

People were supported and encouraged to regain and maintain their independence and do as much for themselves as possible.

People contributed to the planning of their care, providing staff with the information required to help meet their needs. Care plans identified people's strengths and aspirations and how people were to be supported to achieve their goals.

Where complaints were raised, they were investigated and responded to accordingly and where appropriate, lessons were learned. People were confident that if they did raise concerns they would be listened to and action would be taken.

People considered the service to be well led. The registered manager and project manager were well thought of by people, relatives and staff alike.

Staff felt supported in their role and there was an open and honest culture which led to lessons being learnt if things went wrong. Staff were motivated in their role and on board with the registered manager's vision for the service.

People and staff were provided with the opportunity to give feedback on the service, which was then acted upon. There were a variety of audits in place to assist the registered manager in driving improvement across the service.

The registered manager and staff group worked alongside other agencies in order to obtain the appropriate care and support for 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.

People were supported by staff who were aware of their responsibilities to safeguard people from abuse. Staff were aware of the risks to people and how to keep them safe. People were supported sufficient numbers of safely recruited staff. People were supported to take their medicines safely.

Is the service effective?

Good

The service was effective.

Pre-assessment processes ensured staff were provided with the information required to meet people's needs effectively. People were supported by a staff group who received an induction and training which provided them with the skills for the job. People were supported to maintain a healthy diet and good health. Staff routinely obtained people's consent prior to offering support.

Is the service caring?

Good

The service was caring.

People were happy with the care received and described staff as kind and caring. Staff treated people with dignity and respect and supported them to make decisions and express their views. People were supported to communicate with staff in a variety of ways to ensure their voice was heard.

Is the service responsive?

Good

The service was responsive.

People contributed to the planning and review of their care. People were supported to take part in a variety of activities that were of interest to them. Plans were in place to ensure people maintained relationships with their loved ones. A system was in place to receive and investigate any complaints received. People were confident if they complained they would be listened to.

Is the service well-led?

Good

The service was well led.

People and staff considered the service to be well led and were complimentary of the registered manager and project manager. People were confident in the staffs ability to support them. Staff felt valued and supported and were motivated to ensure people enjoyed a good quality of life and reached their potential. There were a number of audits in place to assess the quality of the service provided.

Katherine House

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 5 and 8 January 2018 and was unannounced. The service was inspected by one inspector.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths. We asked the local authority for their views about the service provided. We used the information that we had gathered to plan what areas we were going to focus on during our inspection. We spoke with three people who lived at the service and two relatives. We spoke with the registered manager, the project manager and four members of care staff.

We reviewed a range of documents and records including the care records of four people using the service, two medication administration records, two staff files, training records, accidents and incidents, complaints systems, minutes of meetings, activity records, surveys and quality audits.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe, staff know how to support me." A relative said, "Safe? At first I wasn't sure, I fear for [person], but when I go and visit [person] seems very happy. I've no reason to believe they are not safe. When I talk to staff they reassure me sufficiently." Staff had received training in how to safeguard people from abuse and were aware of their responsibilities to report any concerns. A member of staff said, "People's needs are met, we keep people safe and they always have one to one support." A member of staff told us, "If I saw a safeguarding [concern] I would speak to the manager and take action from there." We saw where concerns had been raised, systems were in place to ensure they were investigated, acted on and reported to the local authority appropriately. We saw where appropriate, actions were taken by the registered manager and lessons were learnt.

People were supported by staff who were aware of the risks to them on a daily basis. Staff spoken with were able to describe the risks to particular individuals and how to manage those risks. For example, one member of staff told us, "You need to be constantly aware of people's movements; you have to assess their mood and if necessary re-direct them to activities. You need to keep people busy and make sure they don't get bored." Risks assessments were in place to identify the risks to people living at the service and when they went into the community. Where accidents or incidents took place, they were reported and recorded. Where appropriate, medical assistance was sought and body maps completed, recording any injuries sustained. Staff were aware of the procedures to follow in these circumstances and we saw evidence where incidents took place they were dealt with appropriately and information was passed onto colleagues on the next shift.

We saw that the service had a robust recruitment process in place. Staff told us that prior to commencing in post, the appropriate checks were made, including references and DBS [Disclosure and Barring Service] checks. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed. We saw where unsafe practices were identified, disciplinary processes were followed and lessons were learnt.

One person told us, "There are enough staff, they are busy, there are some people who need more help". Other people told us they felt there were enough staff to support them and meet their needs and we observed this. We saw that for some people, additional staffing was in place during different times of the day to support them with their care and to enable them to take part in activities and access the community. Apprentices had been taken on to assist in taking people into the community. An apprentice told us, "There are loads of staff, they count me as extra, there are always enough staff" another member of staff said, "There are enough staff, everyone has their one to one or two to one when doing activities."

A member of staff told us, "When on shift I will be told who I will be supporting." We saw that systems were in place to ensure the skill mix of staff was appropriate to meet the needs of the people who were being supported and allocation sheets were completed prior to staff coming onto shift. A member of staff told us, "This morning's allocation was done last night, so no one is waiting around to find out what they are doing when they come on shift."

People were protected by the prevention and control of infection. We noted there were no domestic staff in post to carry out housekeeping duties. We saw staff were allocated particular duties on a daily basis and checks were in place to ensure these tasks were completed. We observed the service to be clean, but taking into account people's personal preferences when it came to keeping their rooms clean and tidy. Where night staff had been given cleaning duties checks were made the following day to ensure these were completed to the standard required.

We saw there were a number of health and safety checks in place to ensure the safety of the people living at the service. For example, the registered manager told us, "Following the Grenfell Tower fire, we completed a review of our procedures and risk assessments and arranged for a fire contractor to look at things to see if we needed to take any further action, but there were no other actions for us to take."

People told us they were happy with the support they received to take their medicines. We saw that systems and processes were in place to support people to receive their medicines as prescribed by their doctor. We saw that people's medicines were stored securely in their own rooms. For those medicines that needed to be stored in a fridge, temperatures were taken twice daily to ensure they were kept at the correct temperature. Staff had received training in how to safely administer medication and had their competencies regularly checked. For those medicines that were to be administered covertly, the appropriate authorisation was in place to ensure this was done in line with people's best interests. We looked at the medication administration records [MAR] for two people and found that the amount of medication given tallied with what was in stock. We noted that since one person had moved to the service, efforts had been made to reduce their 'as required' medicines. A member of staff told us, "The more we learnt about [person's] behaviours the less we use 'as required' medicines. We only give it now if re-direction is not working." This meant that staff were able to recognise potential triggers before behaviours occurred and use distraction techniques to de-escalate situations. This also meant that there was now a stock of medicines that were being held by the service that were no longer required. This was discussed with the project manager who arranged for this to be returned to the pharmacy that day.

Good

Is the service effective?

Our findings

One person told us, "Staff know about me, they are very understanding, you can always chat to them" and another said, "Staff know what is important to me, if I was upset they would definitely listen to me." We saw that people's needs were assessed in line with their health and social care needs. Care records contained information about what was important to people, for example, important relationships people had that they needed support to maintain, people's hopes and aspirations, if they preferred male or female carers or had any religious needs or followed any particular diets. Staff were able to describe to us how this information was collected and how important it was to be aware of it when supporting people. A member of staff described to us how they built up a picture of a person when they first arrived at the service. They told us, "We observe the service user and see how they respond [to situations], it's about lessening the risk, for example, perfume can overflow the senses for some people."

All staff spoken with talked about the importance of people's daily routines. All mentioned one person in particular, as an example and each member of staff provided the same level of detail regarding the person's routine and the impact upon the person if this routine was not followed. One member of staff said, "You have to follow the routine otherwise it would put [person] off and they would have a behaviour." Another member of staff said, "If [person] doesn't have a systematic start to the day they will display a lot of challenging behaviours. You can see the anxiety; they will pull a face, we know structure of [person's] day and all staff are aware of this." Another member of staff told us how one person enjoyed making their own lunches but could become agitated during this task, they told us, "It's important to present [person] with choices; our purpose is to provide support to people with learning disabilities and help them live a full, quality life."

People were supported by staff who had received an induction that prepared them for their role. Staff told us their induction included being introduced to people living at the service and observing their routines, shadowing more experienced staff, looking at care records and being made aware of safety issues. A member of staff told us, "I have had two to three meetings with [project manager's name] and I have no concerns, all my needs have been met to be honest." A staff handbook was also provided, which one member of staff described as, "Having everything to do with your position."

Staff told us they felt listened to and supported by management and benefitted from regular supervision meetings which provided them with the opportunity to discuss their training needs or raise any concerns they may have. A member of staff said, "Supervision is very interactive, we can raise any concerns, it's been a good experience working here and I've got my yearly appraisal soon." A member of staff who conducted supervisions told us, "There are five mandatory questions to ask, giving you chance to raise issues or put comments forward, that's where staff engage and discuss any issues they may have."

Staff told us they felt well trained and were provided with a number of opportunities to improve their learning. Staff were provided with training in mandatory areas and specialist areas that were linked to their role, such as autism awareness. One member of staff added that additional practical training would be helpful and that this had been requested and was being arranged. They told us they had received training in

Mental Capacity Act 2014 [MCA] and Deprivation of Liberty Safeguards [DoLS] and the registered manager had arranged a workshop and group discussions including case scenarios to assist staff with their learning of this subject and enhance or embed their current knowledge. They told us, "You learn a lot through discussion, it was helpful." We saw that staff competencies were then assessed in the subject to ensure they put into practice their learning.

One person told us, "I choose what I like to eat; I like lamb, fish, pasta and pizza." People were supported to eat and drink enough to maintain a healthy diet. Not all people had access to the kitchen due to the individual risks to them. Others were provided with the key code to the kitchen and had their own cupboards to store items they had purchased for themselves. Pictorial menus were on display which enabled some people to make their meal choices. Efforts were made to enable people to eat in a group setting, for example, a brunch on a Saturday which people told us they enjoyed. We saw there was a cultural themed evening every Wednesday to enable people to try different foods.

Prior to people moving into the home, arrangements were made to make the transition as smooth as possible. We saw that people, their relatives and other professionals involved in their care and support were involved in this process. People were supported to visit the service, prior to moving in. This provided staff with the opportunity to build a picture of the person, gathering information regarding the type of person they were and what was important to them and for them. For example, if people had particular routines around personal care or mealtimes, people were supported to provide this information which was in turn, recorded and shared with staff.

People were supported to maintain good health. One person told us, "I feel safe, if I was feeling unwell I would tell them [staff] and they would ring the doctors to see if it's worthwhile me going" and another said, "If I said I wanted a GP they would sort it out for me." A relative described how their loved one had recently become more agitated but was unable to communicate with staff that they were in pain. Staff had discovered the person was suffering from toothache and had arranged a dental appointment. Another relative described how their loved one had been taken ill and told us, "They took them to hospital and got it dealt with. If I'm worried they will do something about it." We saw where one person had recently been discharged from hospital, their health care plan had been updated and their health goals, short and long term, had been amended. All staff spoken with were aware of the changes to the person's care plan following their discharge from hospital. Staff spoken with were able to describe to us people's healthcare needs and how they supported them to maintain good health. Staff told us people's healthcare plans provided them with all the information required to meet people's healthcare needs and we saw these documents were comprehensive and kept up to date.

Plans were in place for the re-decoration of some communal areas. There were two lounges and a large dining room for people to access. One lounge was deemed as the 'quiet lounge' and provided people with an area to spend time alone or to see their visitors. A table was set up near the window to enable one person, who enjoyed creating their own art, to work. The kitchen was accessed via a key code system, which some people had access to and were supported to make their own meals. A conservatory was another area which people liked to sit in. A member of staff told us, "Sometimes people like the privacy of their own room."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this

is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that it was.

People told us that staff obtained their consent prior to offering support and we observed this. One person told us, "Staff do obtain consent" and another said, "They ask me [what I would like to do], it's my choice isn't it?" Staff spoken with had a good understanding of the subject and what it meant for the people they supported and how that impacted on their practice. It was clear from staff responses to this question, that the group discussions that had been put in place to enhance their learning on the subject had been successful. One member of staff told us, "You have to keep people safe, particularly when going outside" and another said, "Even though some people are non-verbal they do understand and you will always ask first, 'do you want to go out to day' and show them pictures and give them different options." We saw evidence that prior to applications being made to the appropriate authorities to deprive a person of their liberty, meetings had taken place to ensure the actions being taken were in the person's best interests.

We saw that there was a change in approach when it came to supporting people who may present behaviours that challenge. People had their own behaviour management booklet which provided staff with details regarding what settled behaviour looked like for a person and how to recognise if a person may be agitated and how to respond to these triggers. The booklet also provided staff with information on how to communicate effectively with people during these episodes and how to respond to each situation. Staff had received training in this new way of working, which focussed on using pro-active strategies and re-direction techniques. Staff spoke positively about this change in approach and one member of staff said, "We use restraint as a last resort, we would constantly re-direct [person], it's only when they are not responding to re-direction and putting themselves at harm that we would use it." The registered manager told us, "We have recently changed our behaviour support to a more holistic system. It's more about being pro-active than reactive. We are using pro-active strategies such as ensuring people are supported by familiar staff and looking for visual clues. Staff have been quite positive about it."

Good

Is the service caring?

Our findings

One person told us, "I love it here and I get on really well with staff who are very helpful" and went on to provide us with the names of several staff who they described as, "All very good." Another person told us, "Staff are kind, [staff member's name] gave me lessons and advice on [using] the internet." From our conversations with people it was clear that staff were mindful of people's emotional well-being and that people felt comfortable approaching staff for support. One person told us, "It's lovely, they have very nice staff, always helpful, any problems there's always someone you can talk to. It's reassuring." We observed staff walk past people, enquire after them and pass the time of day. Staff apologised if they had to move past people, addressed them by their preferred name and showed familiarity and respect in their approach to people.

We saw that people living at the service had a variety of communication needs. A member of staff said, "Each person is very different and how they communicate is different." They went on to provide us with different types of communication used for people living at the home such as picture cards, Makaton and basic hand signals. Care plans provided staff with the information needed to communicate effectively with people. For example, for people who were unable to communicate verbally, information was available that would alert staff as to how someone was feeling such as how to tell they were happy, unhappy, excited, tired, angry, hungry, etc. This additional information provided staff with the tools to communicate effectively with people and respond to their needs in a timely manner.

People told us and we saw, they were involved, where possible, in making decisions about their care, treatment and support. For those people who required the support of an advocate, arrangements were made to access these services. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes. People's support plans reflected the decisions they were able to make themselves when it came how they wished to be supported and what they could do for themselves. For example, how they wished to spend their time, what they wanted to eat and drink and what clothes they liked to wear. One person told us, "Staff support me to do some things myself, like make drinks. They know my little ways and what I can have and what I can't have." We also received the following comments from other people living at the home; "I try to be friendly with everyone, we have a Saturday brunch and you can choose two meals and you can choose what you want", "I do my own washing and drying, I wash my clothes carefully", "I get my own shopping, I like to cook for myself, bacon, sausage" and "I get up and go to bed when I want and I like to spend time in my room."

The provider told us in their Provider Information Return [PIR] that people were supported to express their views through monthly one to one meetings with their key worker. We saw these meetings provided people with the opportunity to discuss any concerns they may have, how they were doing and their plans for the coming month. The information was presented in a pictorial format for those who required it to ensure people were able to contribute to the meeting. People were supported to plan their activities on a weekly basis. Staff rotas were developed in conjunction with these plans, to ensure the correct number of skilled staff were available on each shift to support people to take part in activities they had chosen for the coming week.

People told us they were treated with dignity and respect and we observed this. One person told us, "Staff are respectful if they want to do something different. They always ask what I think first." Another person told us how important their appearance was to them. They told us, "Staff support me to buy make up and toiletries, it makes me feel good and it reflects on you and other people."
One relative told us, "When I'm there the staff are caring and treat [person] with respect" and another relative said, "They have a lot of agency staff and I do worry they have to get to know [person] but they do treat them with dignity and respect." Staff were able to describe how they maintained people's dignity when supporting them with their personal care, for example by ensuring doors were closed and curtains shut. A member of staff said, "Someone like [person's name], I'll ask, do you want me to stay outside, or do you want me to assist?"

People were supported to maintain their independence where possible. Staff were mindful of when to provide or offer support and when to take a step back and encourage the person to do something for themselves. A member of staff described the work in progress to support a particular person to become more independent with their personal care needs, adding, "You look at their lifestyle and think how can we better it?"

A relative told us, "They [staff] are quite nice, kind and caring and pleasant when you go and make you feel welcome" and another relative commented, "I visit regularly and ring in the week".

Good

Is the service responsive?

Our findings

One person told us, "I'm aware of my care plan, I'm a diabetic and I have to be aware of what I can eat" and another person told us, "I am involved in my care plan, we talk through it and go through reviews." Others spoken with confirmed they too were involved in the planning of their care and we saw evidence of this.

We saw people were supported to contribute to their care planning, from the pre-assessment process through to regular reviews of their care. The pre-assessment included trying to identify the right type of staff member to support someone. For example, people were asked if they preferred a male or female carer, someone of their own age and who had similar interests. We saw that one person had answered these questions with the response; "I like to be supported by people who are calm and not too noisy – age does not bother me as I tend to enjoy the company of older and younger people." We saw reviews of people's care took place regularly. A relative told us, "We had a little meeting, they asked for any suggestions and I said they need to go out more and give [person] a bit of life, though [person] is very difficult to motivate."

People's care plans provided staff with information not only of people's care needs, but their family history, likes and dislikes and aspirations. They held positive statements about people, such as, 'things I like and admire about myself' and 'things people like and admire about me'. All staff spoken with knew people well and knew what was important to them. Being aware of this information meant staff were equipped to provide people with care that was responsive to their needs. A member of staff said, "Over time you pick up more about each person and you can constantly refer to the care plan."

We saw monthly meetings took place with people and their key worker to provide them with the opportunity to discuss their support, their aspirations and any concerns they may have. That said, people did not have to wait until the monthly meetings for these discussions and each person spoken with commented positively about staff and how accessible and supportive they were.

One person told us, "I go to bingo on Thursday night, I like doing art and go to art class. I go out nearly every day" and another said, "I do ask if I can go places or they ask do I want to go somewhere for coffee and I like a giant tea cake." People were supported to take part in a variety of activities that were of interest to them. People had weekly meetings with their key worker to look at activities they would like to do for the week, which was then written in their own diary. One person told us, "I like watching DVDs, browsing the internet, puzzles. I like to go for coffee and shopping." Another person said, "I like to go the shops. Three to four of us go out at once and I like to have a little mooch [look] around the shops." Another person was supported to attend an art club and proudly showed us their art work which had been framed and placed on the walls in the communal areas for everyone to appreciate and enjoy. The project manager told us, "People have access to the community; it's bespoke, based on what individuals want to do." We saw many photos on display of people taking part in the activities they enjoyed to demonstrate this. On the day of the inspection, a group of people had decided to go swimming at the local pool. It was clear people were looking forward to this activity and relatives spoken to confirmed their loved ones enjoyed doing this. One relative was keen to see her loved one access the community more and the registered manager confirmed that two staff had recently become authorised drivers for the service. People had set individual goals when it came to their

activities and were supported to achieve these. For example, plans were being made to take people on holiday later in the year; one person was looking forward to watching the live recording of a television programme they enjoyed and plans were in place to apply for an allotment for two other people to tend to.

We saw that people were supported to maintain relationships. Visitors told us they felt welcome when they visited and people told us they were supported to visit their loved ones on a regular basis. A relative said, "They took [person] to Blackpool in November and I met up with them and it was really good and [person] wants more of that. They like travelling and they are talking of taking [person] on holiday in the summer for three days."

A relative told us, "Permanent staff know [person] but sometimes when there are agency staff, they don't understand them. Some are better than others, you have to know [person], it takes time to build a relationship." We saw people's communication needs were routinely taken into account during the pre-assessment process. Communication passports were created for use when people were visiting new places such as their GP, the hospital or the dentist. Information made available to people was also provided in a pictorial format for those who required this additional support. This included the service user guide, complaints procedure, monthly reviews and care plans. Where staff wanted to communicate something specific with a person, for example, the response to a complaint, the project manager had access to a system which produced pictorial guides to replace individual words. This provided staff with an alternative way of engaging with the people they supported.

One person told us, "I know how to complain. I would just tell them [staff]. I did complain and they did something about it" and another person said, "I've no complaints, but I know how to complain." Relatives told us, "We've had a few reviews since [person] has been there and everything has been addressed" and "I'm giving it a chance, it's early days on the whole and any concerns there have been they have been dealt with by [project manager's name] in a timely way. They keep me up to date and do call me and give feedback." We saw there was a system in place to support people to make a complaint. Where complaints were received they were logged, investigated and where appropriate actions were taken.

There was no one currently at the service who was receiving end of life care. Where possible, conversations had taken place with people regarding their wishes and end of life care and information was gathered and kept under review.

Good

Is the service well-led?

Our findings

People told us they were happy with the service they received. One person said, "[Management team names] are very approachable, very pleasant and understanding. Overall, there's a very friendly atmosphere" and another person said, "[Registered manager's name] is nice, he is genuine and he helps you." A relative told us, "The project manager seems quite nice and [registered manager's name] is quite good" and another relative said, "I don't know anywhere better really, [person] knows the people and likes them." Staff were complimentary about the service and considered it to be well led. One member of staff told us, "It is nice. I wouldn't think twice if a family member needed to come here. It is more relaxing for residents. It's a good place to work, your questions aren't ever ignored." Another said, "I would recommend it, it's really lovely. We work together, working as a team is a big thing here. People are supported to full capacity."

People were supported by a group of staff who told us they felt valued and supported in their role. Staff presented as motivated and were on board with the registered manager's vision for the service. One member of staff told us, "When [person] first came here, their independent living skills were well below par. We are building them up and the goal is for them to be more independent and give them a good lifestyle and feel safe." The registered manager and all staff spoken with were open and transparent when talking about the challenges the service had faced in recent months. For example, all spoke of the confusion and problems that arose whilst the service trained staff in a new way of supporting people. One member of staff said, "During the change, the person doing the training left and we had new staff come in at the same time. There was uncertainty as to who was doing what." The registered manager confirmed the change had created some issues. However, all spoken with told us that the changes that had been introduced had had a positive impact on the people living at the service. A member of staff reflected on this and told us, "[Registered manager's name] has the respect of a lot of the staff, the way he communicates with them. If staff have an issue he will take on board what people say. He will process what needs to be done and all service users get the best out of the service."

The registered manager and project manager had a comprehensive knowledge of the people living at the service. A member of staff told us, "[Project manager's name] is always walking around, she's checking on people, she is a people person. Both her and [registered manager's name] are very approachable."

People were supported by a group of staff who knew what was expected of them. Support was available to staff from the management team and an out of hours on call service. The registered manager told us they were fully supported by the provider and other colleagues who brought other areas of expertise to the service such as behaviour management and quality assurance. The registered manager told us, "There is an on call system, but the senior team are quite experienced therefore it's rare there is an issue." We saw at the end of each shift, management were emailed copies of the handover that had taken place to alert them to any issues that had taken place that day. We saw the registered manager screened handover sheets and followed up any concerns to ensure the appropriate actions were taken. Staff were complimentary about each other and the service as a whole and spoke positively about the changes that had been introduced by the management team. A member of staff said, "Staff do a great job, everyone tries and are empathetic, they

are organised, everything has been sorted from scratch and now runs like clockwork. [Registered manager's name] has systems in place to run the unit; there's no pressure as it's not all on your shoulders; there's been a lot of positive changes". We saw the registered manager arrange additional training sessions for staff including discussions on subjects to enable staff to learn particular subjects effectively. The registered manager had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.

There were system in place to involve people in the development of the service. A member of staff said, "We have monthly staff meetings everyone raises points and things are accomplished." We saw that staff views were sought on the service and their voice was listened to. For example, a member of staff raised an issue that daily recordings were not being fully completed. This was raised at the meeting and conversations with staff took place to ensure they understood the importance of completing this paperwork fully on a daily basis. Staff were aware of the whistle blowing policy and told us they were confident if they raised concerns they would be listened to.

We saw that questionnaires were completed by people living at the service, in a format that they could understand and the information obtained was analysed and an action plan produced to address the issues raised. However the registered manager told us, "For some people, I felt it was a bit tokenistic; in future will not do questionnaire as for some people we are unable to gain feedback effectively due to their communication issues." They told us and we saw, that feedback was now regularly obtained from people every month. This process, including analysing people's behaviours during the month, provided the service with a picture of how people were feeling.

The provider told us in their provider information return [PIR] that they intended to carry out 'family forum' providing relatives with the opportunity to raise any questions they may have. The registered manager told us the purpose of the meeting, was to obtain "More rich information from people" regarding their loved ones. It also provided people with the opportunity to raise any other concerns they may have which they did not want to address through the complaints process. We saw that when questionnaires had been issued to relatives in July 2017 it had been raised by one respondent that they were not aware of the complaints process. Following this, information on the complaints process was reissued and the matter was also raised at the family forum meeting that was held in October 2017.

We saw there were effective quality assurance systems in place to drive improvement across the service and monitor the care provided. A variety of audits were in place, the findings of which were collated and any areas for action were identified and an action plan produced. The system used was 'live' and provided the registered manager with an instant update of progress against actions identified. This was regularly reviewed to ensure areas identified for improvement were acted upon in a timely manner. The service benefitted from employing their own behaviour manager who worked closely with services and multi-disciplinary teams with a view to getting the best outcomes for people. The registered manager told us they kept up to date with changes in practice through a number of avenues including the Skills for Care website and the monthly CQC newsletter for providers. We saw that good practice was shared by the provider and managers of other services through meetings and the provider's newsletter.

The registered manager and staff group worked in partnership with a number of other agencies and professionals to support care delivery such as a diabetic nurse, occupational therapists and speech and language therapists. The registered manager told us, "We are piloting something at the moment. We wanted input from the occupational therapist and speech and language therapist. They are putting together some person centred prompts for [person] to encourage them with their independence on a daily basis; it's working quite well."