St David's APL Limited

St David's APL

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 22 and 23 September 2016 and was unannounced.

St David's APL (Active Programmes for Life) provides accommodation and support for up to nine adults with a learning disability or autism. At the time of the inspection the home was fully occupied. People had complex care and communication needs due to their learning disabilities and this meant we could not talk fully with everyone who lived at the home. We therefore used our observations of care and our conversations with staff and people's relatives to help us understand their experiences.

The service had 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.

During our inspection we saw staff providing care of a good standard and people were relaxed and happy. However, there were some areas of care that required improvement.

The Mental Capacity Act (2005) and deprivation of Liberty Safeguard were not fully understood or being implemented by the registered manager or staff. This meant people's legal rights may not be fully protected. The registered manager took immediate steps to remedy this. By the second day of our inspection, all staff were booked on to appropriate training, provided by the local authority, to ensure their knowledge and practice was brought up to date.

People's freedom of movement around the home was restricted as the dining room and kitchen, which were joined, were locked unless there was a member of staff present. The registered manager told us this was to manage possible risks for one person in relation to the kitchen area. However, the impact of this was to restrict access to communal areas of the home for everyone. The registered manager and provider told us they would cease this practice and focus on managing individual risks in the kitchen area. They said they would review how the two rooms were joined to ensure the risks for the individual concerned were managed in a way which did not put restrictions upon others living in the home.

Records showed each person had assessments of potential risks to their health and welfare. Where risks were identified, care plans or 'personal profiles', were in place that gave guidance for staff about how to reduce the risk. Staff had a high level of knowledge about people's individual care needs and were skilled at meeting people's complex needs. However, this level of knowledge was not always reflected in people's care records. For example there was little guidance for staff regarding how to meet one person's complex communication needs. We saw no detrimental impact on people from this, but the care records would not necessarily provide sufficient detailed guidance for a new member of staff or agency staff to be able to fully meet a person's care needs. We discussed this with the registered manager who told us they would seek up to date guidance regarding best practice in relation to care planning and review all records to ensure they

reflected this.

People appeared relaxed and comfortable living at St David's; smiling and responding warmly to care staff. This indicated they felt safe and secure within their home. One person said "Staff are 100% kind". Relatives told us they were very happy with the care provided. One person's relative said "[Name of relative] wouldn't be there for a second if I had any qualms about his safety. I am confident he's as safe as he can be living at St David's". Staff received training in safeguarding adults and knew how to raise concerns if they were worried about anybody being harmed or neglected.

The culture of the home was person-centred open and friendly. Staff treated people with kindness and respect and offered people choice in all aspects of their care. For example in relation to meals, bedtimes, activities and how people liked to spend their day. Staff worked closely with people to ensure they understood their needs and preferences. People were involved in planning and reviewing their own care as fully as they were able. Staff ensured people's privacy and dignity was respected at all times. They always checked with people before providing care or support and respected people's decisions.

People's relatives said they were made very welcome and were free to visit the home as often as they wished. They said the service was very good at keeping them informed and involving them in decisions about their relatives care.

People were engaged in a variety of activities within the home and in the community and there were sufficient numbers of staff to support this. People were encouraged to be active and maintain their independence as far as they were able and to be part of the local community. This helped ensure people experienced a good quality of life.

We observed medicines being administered and this was done safely and unhurriedly. Staff received regular training in medicines management and medicines audits were completed to ensure consistent safe practice. People were supported to maintain good health by external health and social care professionals where necessary.

There were enough care staff to meet people's complex needs and to care for them safely.
Recruitment processes ensured that suitable staff were employed. Staff were well supported by the registered manager through supervision and appraisal. High standards of care were encouraged through staff training and development. Staff participated in a wide range of training courses in topics relevant to people's care needs, including diabetes, epilepsy, person-centred care and first aid. The registered manager recognised that staff would benefit from specific training in autism and had made arrangements with the local learning disability team to access this.

People were supported to eat and drink enough to ensure they maintained good health. We spoke with people about their meals and observed the lunchtime meal and saw everyone enjoyed the meals provided and staff supported people appropriately.

There was an ongoing programme of maintenance at the home with work going on at the time of the inspection to replace carpets and refurbish some rooms. The home was clean and odour free. The home was decorated and furnished in a comfortable, homely way. The service had sought input from a specialist healthcare professional to assess the suitability of the environment for people with autism and whether any adaptations were needed. This work was planned but had not happened at the time of the inspection.

There was clear leadership from the registered manager and people and relatives had confidence in them.

Quality monitoring systems were in place to help the service to maintain standards of care and to promote continuing service improvements. However these had not identified the issues we found during the inspection. We discussed why this might be with the registered manager. They were open and honest in their appraisal of the situation and acknowledged they had fallen behind.

We identified one breach of regulation at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe:

Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

People were supported by sufficient numbers of safely recruited and trained staff.

People were protected from the risks associated with medicines.

Is the service effective?

Requires Improvement

The service was not always effective:

People's legal rights were not fully protected because the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not fully understood or being implemented.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported to have access to health professionals including GP's, specialist nurses and dieticians to help them have their health needs met.

Is the service caring?

Good

The service was caring:

People's needs were met by staff with a caring and warm attitude.

People lived in a home that was relaxed and friendly where relatives or friends were welcome to visit.

People's right to privacy and dignity was respected.

People were encouraged and supported to maintain as much

independence as they could.

Is the service responsive?

Good

The service was responsive:

People's care plans did not always fully describe their needs. However, staff knew people well and this did not have any detrimental effect.

People received personalised care that was responsive to their needs.

People were supported to engage in activities of their choice.

Relatives felt able to speak out if they had any concerns and that their complaint would be dealt with.

Is the service well-led?

Good

The service overall was well led:

People benefitted from a service that had a registered manager and a culture that was open, friendly and welcoming.

People's rights were not always protected in line with current legislation and quality monitoring systems had not identified this.

People and relatives' views were sought and taken into account in how the
service was run.

People and relatives had a high level of confidence in the registered manager and said the service was well run.

St David's APL

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.

The inspection took place on 22nd and 23rd September 2016 and was unannounced. It was completed by one social care inspector.

Before the inspection we reviewed information we held about the service. This included previous contact about the home and notifications we had received. A notification is information about important events which the service is required to send us by law. We found there had been no notifications made by St David's. Prior to the inspection we requested a Provider Information Return be completed. This is a form that asks the registered provider and manager to give some key information about the home, what it does well and any improvements they plan to make. However, the provider told us they had not received it.

We met seven people who lived at the home and spoke with three of them. We spoke with three members of care staff as well as the registered manager and the director of the service. Following the inspection, we spoke with two health care professionals who had contact with the home and two relatives of people living at the home.

We looked around the premises, spoke to people individually and spent time with people in the communal areas. We observed how staff interacted with people throughout the day, including during lunch. We looked at three sets of records related to people's individual care needs; three staff recruitment files; staff training, supervision and appraisal records and those related to the management of the home, including quality audits. We looked at the way in which medicines were recorded, stored and administered to people.

Good

Is the service safe?

Our findings

People living at St David's APL were all living with a learning disability. Some people were not able to express themselves verbally and could not tell us if they felt safe living in their home. However, we saw interactions between people and staff that indicated people felt safe. For example, people smiled when staff approached them and were relaxed in their company. People who could communicate verbally told us staff were kind. One said "staff are 100% kind".

People's relatives told us they did not have any concerns about their relative's safety. One of the relatives said "[Name of relative] wouldn't be there for a second if I had any qualms about his safety. I am confident he's as safe as he can be living at St David's". All of the people we saw looked happy and no one appeared anxious or displayed signs of distress. Staff told us they had never had any reason to raise concerns about any of their colleagues.

People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they were confident that if any concerns were raised with management they would be dealt with to make sure people were protected. We saw a safeguarding concern about one person had been dealt with appropriately by the registered manager. They had alerted the local authority safeguarding team and worked closely with the person's social worker in order to keep this person safe.

Not all staff were aware of whistle-blowing procedures, whereby they could report any concerns to external agencies such as the CQC 'in good faith' without repercussions. We discussed this with the registered manager who took immediate steps to book themselves and staff onto safeguarding training provided by the local authority. They told us whistle-blowing would be added to the next staff meeting to ensure all staff understood these procedures and were aware of the home's policy regarding whistleblowing.

People's finances were kept safe. People had appointees to manage their money where needed, including family members. Money was kept securely and staff signed money in and out. Receipts were kept to enable a clear audit trail on incoming and outgoing expenditure and people's money was audited at the end of each day by the registered manager of shift leader.

People were protected from risks associated with staff recruitment. The home had followed a full recruitment process in the staff files that we saw. This included disclosure and barring checks (DBS) and obtaining a full employment history. Staff were not allowed to start work until satisfactory checks and references had been obtained.

Staff understood and respected people's rights to make decisions, including taking risks. The avoidance of risk was not seen as a reason for limiting people's experiences or curtailing activities. We saw people were encouraged to take risks in a supported way, particularly in relation to participation in outside activities. For example, people took part in a wide range of physical activities including rock climbing, kayaking and walking on Dartmoor. Comprehensive risk assessments for all such activities were in place to enable them to

take place as safely as possible.

Each person's care records included risk assessments that were based on their individual risks. These covered a broad range of subjects including their specific health conditions, social and leisure activities, personal care, managing finances, 'challenging' behaviours and people's safety, both in and out of the home environment. Each person had a personal profile and 'Daily Routines' guidelines that gave staff guidance about how to avoid or reduce areas of risk. For example where one person needed a gluten free diet, staff were guided to check all food labels for gluten content and ensure food was always prepared separately to prevent any risk of cross contamination. Where people were diagnosed with specific health conditions such as diabetes or epilepsy, their care records held detailed information about this and what precautions staff should take to keep people safe and prevent complications. All staff we spoke with held comprehensive knowledge about this and were aware of the guidance in each person's personal profile plan.

St David's is an old building and work was underway to modernise it. Two people had glazing in their bedroom windows that was not safety glass or covered with a protective safety film. This could cause a risk of injury if a person was to fall against or through the glazing. The registered manager gave assurance that these windows would be included in risk assessments of the premises and that adequate precautions would be taken to ensure people's safety pending replacement of the glass, or covering with protective safety film.

Staff knew what to do in emergency situations. For example, protocols had been agreed with specialists for responding to people who had epileptic seizures. Staff received training in providing the required medicines and knew when and who to notify if people experienced prolonged seizures. Staff told us if they had significant concerns about a person's health they would call 999 for the emergency ambulance service or speak with the person's GP.

Records showed there had been very few accidents or incidents within the home. There had been a small number of incidents recorded where one person slapped staff when they became distressed. Action had been taken to address this by seeking support from specialist learning disability services. An initial assessment had been completed which identified environmental improvements could be made to reduce the amount of stimulus in communal areas of the home. The registered manager and staff were keen to progress and implement this.

There were sufficient numbers of staff deployed to meet people's care needs and to keep them safe. On the days of the inspection there were seven people at the service during the daytime as some people were away, either at work placements or on holiday. Three care staff were on duty and the registered manager told us this was the minimum staffing level they judged to be necessary in order to meet peoples care needs safely. The registered manager told us they recognised one person's needs were more complex and took more staffing time. They were currently recruiting for an additional member of care staff to be able to spend more time individually with this person and to have more flexibility in the staff team. Use of agency staffing was kept to a minimum as it was recognised that people benefitted from consistency and knowing their care staff. The registered manager worked as part of the staff team but also had 2 days per week allocated for management administration tasks.

A domestic assistant had recently been employed and they provided support with cleaning during the week. Staff reported what a positive difference this had made to their working day and to the time they could spend with people. Tasks such as cooking and laundry were still completed by staff, often assisted by people living at the service. Staff were confident they had sufficient time to complete these tasks. Staffing at night time, between the hours of 10.30pm and 09.30 was provided by two members of staff who slept at the service. The registered manager told us they would remain awake if someone was unwell or required

additional support. However, this was not generally needed. Everyone living at St David's had been individually assessed as having no night time care needs that required waking staff.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the MCA was not fully understood or being applied and this meant there was a potential risk of people's human rights not being respected.

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that there was little reference to the MCA in people's care records. Mental capacity assessments and best interests decisions were not routinely considered or completed as you would expect in a service where people may not have capacity to make specific decisions. Only one person had a best interest's decision that had been recorded in line with the clear guidance set out in the MCA Code of Practice. However, this had been prompted by the person's social worker and not by the service itself. Some people who lacked mental capacity to be able to manage their financial affairs, had appointees to support them with managing their monies. There were no mental capacity assessments in place to reflect this. We discussed these concerns with the registered manager. They demonstrated an understanding of the basic principles of the Act, for example, that people should be supported wherever possible to make their own decisions. However they acknowledged they did not have a comprehensive understanding. Staff were also unconfident in their knowledge in relation to the MCA. They told us they had received some training, but this was some years ago in 2008. This meant they had not had an opportunity to refresh their knowledge and understanding since key changes to legislation had been made in 2014.

Although the correct legal process was not consistently being followed, we saw the registered manager and staff held core values and principles that were consistent with the MCA. For example, people were all encouraged to make their own choices as far as they were able regarding what they wanted to wear, what they ate, what activities they engaged in and how they spent their day. We saw a meeting had been held for one person to consider their best interests regarding home visits. This had involved the person, their family and social worker. Although this had not been recorded in line with the guidance within the MCA code of practice, there was no evidence of any negative impact on people living at the service.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. We saw a DoLs application had been made for only one person, where it had been requested by a local authority. DoLs applications had not been made or considered for others who met the criteria for

assessment under DoLs. We discussed this with the registered manager. They were not aware not aware of the criteria for making an application to the local authority to assess and authorise a DoLS.The registered manager took immediate action by contacting the local authority and requesting appropriate training. We saw this was in place by the second day of our inspection.

We observed people were not always able to move freely around their home. This was due to the dining room being locked unless a staff member was present. We spoke with the registered manager and provider about this. They told us the dining room was locked because it adjoined the kitchen and there were potential risks associated with the kitchen for one person who had recently moved into the home. This meant people's freedom to move around the home and have choice about using the communal dining room was restricted in response to risks for one person. The registered manager acknowledged this concern and gave assurance that staffing would always be sufficient to ensure people could access the dining room whenever they wanted. They also started discussion with the provider about how the two rooms could be divided.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had sufficient to eat and drink and received a balanced diet. People with special dietary needs were assessed by a dietician. For example, one person who had recently been diagnosed with a gluten intolerance had been assessed by a dietician. They had also checked all menus and approved their suitability. Another person had difficulty swallowing and always had a softer diet. We saw they received this and ate well. People at risk of malnutrition were weighed regularly. No one was currently losing weight, but the registered manager was confident they could access nutritional advice should this be necessary.

Staff planned menus for two weeks ahead based on people's known preferences. The member of staff responsible for menu planning had attended diet and nutrition training and told us they planned meals carefully to be healthy, nutritious and appetising to people. People tended to have a light meal at lunchtime, such as beans on toast or a bacon sandwich. Main meals in the evenings included sausages and mash, tagine and cous cous, chicken korma, lasagne, pizza and Sunday roast. Fresh fruit and vegetables were available at mealtimes. We saw there was only one main meal option available and asked staff about this. They told us menu choices were all based on foods they knew everyone liked, but they were happy to change and be flexible to meet people's preferences on the day. Alternatives were always available if people changed their minds or appeared not to like the meal offered. We saw one person push away a bowl of ravioli at lunchtime and staff offered an alternative of beans on toast, which they enjoyed.

We observed care practices over the lunch time period. Everyone was able to eat their meal independently. People appeared to enjoy their meal and no one was rushed. We heard staff encouraging people to eat their meals and engaging people in friendly chat throughout the meal time period. They continually checked to see if people were happy and whether they wanted anything else. We observed during the inspection that no one was offered snacks between meals, such as fruit or biscuits. We asked staff about this and one staff member said "residents eat well at mealtimes, so they tend not to ask". We talked with the registered manager who said snacks were always available if people asked. We questioned whether people who had limited communication would be able to ask, but the registered manager was confident they knew peoples communication styles well enough to identify if they were hungry. The registered manager told us they would talk with staff and remind them that people could always be offered snacks between meals.

Staff carried out regular health checks to help people maintain good health and identify any changes. The deputy manager said the local GP was "brilliant" and healthcare professionals from the practice would visit if requested. Where one person's changed behaviours had indicated they were not feeling well, staff had

been persistent in seeking healthcare reviews and assessment until a cause was identified. With appropriate treatment, this person's behaviours were more settled. Other professionals provided input and advice as needed. This included specialist nurses, speech and language therapists and a neurologist. Care plans contained records of hospital and other health care appointments. Some people with more complex needs also had an assigned social worker to act as their care manager.

One person was able to tell us staff met their care needs well. They said "Staff here get my little ways. My keyworker is the best. He knows me so well". Other people were not able to express their views about how staff met their care needs, but they appeared well cared for and seemed happy with the support they received from staff. People's relatives told us they felt the service was effective in meeting people's needs. They said the staff had a very good understanding of their relative's needs and preferences. One relative said "They know him so well. They are so on the ball; it's the best it can possibly be".

Staff were very knowledgeable about each person's individual support needs and provided care and support in line with people's personal profiles. Staff told us they received training to ensure they knew how to effectively meet people's care needs. This included safeguarding, first aid, infection control, moving and handling, administration of medicines and challenging behaviour. Advice and training was obtained from external specialists when needed, for example in relation to epilepsy and diabetes. Specialist autism training had not been completed, however, the registered manager had recognised the need for this and had already made arrangements for this to be provided through the local specialist learning disability team. Training in relation to MCA and DoLs had been booked in the next month to ensure all staff were able to understand and apply this important legislation and guidance.

Staff told us the registered manager was keen to support them with continuing training and development such as vocational qualifications in health and social care. The staff group was established and only one new member of staff had been recruited in the past year. New staff undertook a detailed 6 week induction programme, following the 'Skills for Care' care certificate framework. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support.

The registered manager told us they worked alongside staff, so had lots of opportunities to observe practice and check staff had the right attitudes and skills for the job. Their competency was assessed over a six month probationary period against written standards of performance. All staff individual supervision sessions every two months as well as an annual appraisal where they could discuss their performance and development needs.

Staff said everyone worked well together as a very friendly and supportive team which helped to provide effective care. One member of staff said "We all get on brilliantly together. There's always someone to ask if I have any queries". Care practices were also discussed at one to one staff supervision sessions and at monthly team meetings with the registered manager.

Staff were skilled at understanding peoples individual communication styles and this enabled them to communicate effectively with people. Some people were able to have conversations with staff but had limited understanding due to their learning disability. Some people were unable to speak but communicated through physical signing (Makaton), facial expressions, body language, physical gestures or finger spelling. Some people had developed their own signs and gestures and staff knew these well, for example, to ask for a cup of tea, to express hunger, or to go to the toilet. We observed people making choices in ways that suited their individual communication methods. For example, some people showed they preferred a particular choice by pointing or alternatively pushing away things they did not want.

Structure in the day was very important for some people and we saw a board in the dining room was updated daily to communicate who was on duty and what was happening each day for each individual. Photos of the staff on duty were used, as well as pictures and words to ensure everyone could clearly see their plan for the day and who would be working.

Some adaptations had been made to the premises to support people's needs. For example an accessible 'wet room' type bathroom had been installed to enable people who were less mobile to shower easily. Significant work was going on at the time we inspected. For example, carpets on the hallway and stairs were being replaced and a new bathroom suite was being installed for one person. A new office area was being built on the ground floor. A member of staff told us they had been waiting some time for these refurbishments and were very pleased they were now being completed. The registered manager anticipated that they would make further changes to some aspects of the environment in order to make it more suitable for people living with autism. They told us they were awaiting training to guide them about this, but were open to making any necessary changes.

The home had a large well-furnished TV lounge and good sized outside spaces. People were all sufficiently mobile to be able to access the various parts of the home independently.

Good

Is the service caring?

Our findings

Some of the people living at St David's had complex care needs in relation to their learning disabilities. Due to this they were unable to discuss in great detail their views about the care they received. However, one person said "I'm happy here" and another said "staff are extremely kind". People's relatives told us they were happy with the way staff cared for their relatives. One person's relative said "The caring and supportive attitude of staff must be praised". Another said "staff are highly committed and caring. They want the best for [name of relative] as much as we do".

The atmosphere in the home was relaxed and friendly. The registered manager encouraged people to come and speak with them whenever they wanted. People approached staff easily and comfortably and staff responded to them a friendly, considerate and patient manner. People and staff sat in the lounge together chatting in an unhurried, relaxed and sociable way. They appeared confident and comfortable in their home. We heard one person request to do some drawing and a member of staff asked if they would like to go out with them to buy a new colouring book. They went off and did this, then came home and sat companionably together in the lounge chatting and drawing.

Although some people's verbal communication and language skills were limited, they understood when staff spoke with them and often responded with happy facial expressions such as smiles or made happy vocalisations. Staff told us they enjoyed their job and cared greatly about making lives as rewarding as possible for people. One staff member said "I love seeing the guys here enjoying themselves. It is so rewarding – seeing them having fun and laughing. I just want to do my best for them". Another said "Every day is so different with the residents. It's great seeing them happy. There's a good atmosphere and camaraderie between everyone!" The registered manager told us how important it was to recruit staff with the right caring attitudes. They said "At job interviews I look for personality and empathy rather than formal qualifications. They've got to be calm and caring, understanding and patient".

Staff understood people's needs and preferences and engaged with each person in a way that was most appropriate to them. Some people had limited verbal communication skills and lacked understanding due to their learning disability. They communicated through physical forms of expression or other vocalisations. They had lived in the home for many years and staff had become familiar with their preferences and individual ways of communicating. Nevertheless, members of staff still checked to make sure people were happy with the choices offered to them. For example, we heard members of staff checking with people about food choices and how they wanted to spend their time.

People were encouraged to maintain as much independence as possible. Staff told us they supported people to manage aspects of their care themselves. For example, many people were able to wash and dress themselves with some prompting. People were also encouraged to take part in assisting with meal preparation and household tasks such as cleaning their rooms.

The registered manager told us they were supporting two people currently living in the service to develop sufficient independent living skills to move on into supported living arrangements. One person told us they

felt they were very happy with the support staff provided them to develop their independence. For example, they had access to a self-contained lounge and kitchenette area where they could prepare simple meals and make drinks. Staff encouraged them to develop budgeting and shopping skills by giving them a weekly allowance to buy and prepare their own meals. Staff were liaising with the local authority to complete the necessary reviews in order to support the move to more independent supported living.

Staff treated people with dignity and respect and all personal care was provided in private. One person was encouraged to eat independently and in doing so, dropped food on the table and floor. Staff praised them for eating so well, and then discreetly cleared up once they had left the table. Another member of staff told us they always assisted one person to a private space before giving them their insulin injections and we observed they did this. We saw staff always knocked on people's doors and sought consent before entering. Privacy and dignity was referred to in people's care records. For example, one person's personal profile included guidance for staff saying: "ensure (name of person) is appropriately dressed walking to and from the bathroom after their bath to protect her dignity."

Staff spoke to people in a respectful and caring manner. When staff talked to us they were always very respectful in the way they referred to people. We observed staff responded politely to people's approaches even when they were already busy supporting someone else.

People were supported to maintain ongoing relationships with their families. Relatives were encouraged to visit as often as they wished and told us they were always made to feel very welcome. There were no restrictions to when they could visit. Staff also supported people to visit their families by making necessary arrangements and helping with transport where necessary.

Good

Is the service responsive?

Our findings

People contributed to the assessment and planning of their care to the extent they were able to. Staff understood people's individual communication needs well and assisted them to express their needs and preferences in ways they could understand. A relative of one person who could not communicate verbally said "Staff understand (their relative's) signs and they would know if anything is wrong". Relatives were encouraged to participate in discussions about people's care plans and to express their views. One relative said "I am 100% involved in his care. We do everything in conjunction with each other. We all want the best for [relative's name] and we work together to get there." They told us they spoke with staff every day and had total confidence that staff would let them know if anything is was wrong.

People were empowered to make choices and have as much control and independence as possible. For example one person was unable to dress themselves or verbally communicate, but staff knew they were very particular about the logos on their clothing. They had a large collection of tee shirts and liked to choose which to wear. A member of staff told us about supporting this person to dress and said: "I'll pull out a dozen tee shirts before the sour face turns to a happy face and then I know we've got to the right one and it's a good day!"

Each person had a care record called a personal profile which was based on their individual support needs. These included limited guidance for staff on how to support people's individual needs. They also included information about people's likes and dislikes, daily routines and activity preferences. When we looked at the personal profiles we saw they did not always reflect the comprehensive knowledge staff held about people's needs. For example, one person was not able to communicate verbally and had complex physical care needs due to a specific health condition. We had seen staff support this person with great skill, sensitivity and understanding. They knew that the person's lack of verbal communication placed them at great risk as they were unable to express when they were feeling unwell. Staff had an understanding of this person's signs and gestures that enabled them to carefully monitor any changes. They knew what actions to take should their behaviours change. However, the personal profile contained no detailed information regarding communication, saying only that the person "can use limited signs of Makaton". Another person became anxious and distressed at times. Staff were able to tell us how they reassured them and distracted them. However, this area of care was not included in their personal profile. We spoke with the registered manager about the care records not reflecting the high quality of care staff were providing to people and showed them examples of this. They acknowledged this. They said staff were so established and knew people so well, that records had not always been updated as they should. They were keen to improve personal profiles and advised they would take advice from the local authority learning disability team to ensure this was completed in line with current best practice.

People's needs were reviewed regularly and as required. Where necessary, external health and social care professionals were involved. For example, we saw one person's health needs had recently changed. The registered manager had recognised this may have implications for other aspects of their healthcare. They had taken prompt action to seek guidance and support from a specialist diabetes service. All risk assessments and personal profiles were reviewed at least annually or more frequently if required. Relatives

or advocates were invited to take part in people's reviews where this was appropriate. Everyone living at the service had a meeting with their keyworker every three months where any changes to needs, concerns or ideas were discussed. Keyworkers fed back to the registered manager from these meeting which ensured information was kept relevant and up to date.

Where people or their relatives expressed a preference for support from a particular member of care staff the service tried to accommodate these preferences. For example, in relation to who they wanted to accompany them for an individual activity. Staff members of the same gender were available to assist people with personal care if this was their preference. For example, one female preferred to be supported by female care staff and we saw staff always respected this preference.

For most people living in the service, structure was important in their day. A board in the dining room showed pictures of the staff on duty over the next 24 hour period and also the daytime and evening activities for individuals and groups for the week ahead. Staff also spent time with people explaining what would be happening during the day. We saw staff were patient and happy to repeat information as often as required to enable people to be reassured about the structure of the day.

People had their own individualised bedrooms. Each room was furnished and decorated to the person's individual needs, tastes and preferences. Staff told us people were free to choose the colour of their rooms and we saw one person's room reflected their love of all things pink.

People were supported to spend time in the community and to participate in a range of activities in line with their personal interests. This included visits into the Dawlish, the local park, shopping trips, cinema trips, lunches, clubs, discos, local church services, day trips to the seaside and other places of interest. Part of the home's philosophy of care was that activity is important to people's wellbeing and the staff group included an activities coordinator who planned group and individual activities with people. They told us that, with support and encouragement, people living at St David's had been able to take part in a wide range of outdoor activities. These included horse riding, kayaking and rock climbing. One person told us how proud they were of their rock climbing and another told us they had enjoyed a boat trip. Several people attended work placements at a local garden trust for either one or two days a week and people told us how much they enjoyed their work.

Activities available within the home included watching TV and DVDs, reading materials, playing games and socialising with staff. Staff told us people could always access the home's private gardens at the rear of the building, although we didn't see these being used during the inspection.

People's relatives and the staff told us the registered manager was always accessible and visible around the home. Relatives were encouraged to feedback any issues or concerns directly to the manager or to any other member of staff. One relative said "If I had any concerns I would talk to the staff. They are all very amenable and approachable. They are very good". Relatives said the management regularly called them to let them know if there were any issues or updates regarding people's health and well-being.

The provider had an appropriate policy and procedure for managing complaints about the service which was displayed clearly in the home. This included agreed timescales for responding to people's concerns. We were told no written complaints had been made about the service. A simplified easy read version was also available in people's care records and in their bedrooms. One relative said "I've never had any reason to complain". Another relative told us they raised a concern a long time ago and it was dealt with immediately and satisfactorily.

Good

Is the service well-led?

Our findings

Relatives and staff told us the home was well managed and the registered manager was always open and approachable. Policies and procedures were in place, together with quality assurance systems to monitor the quality of care and plan ongoing improvements. However, these systems were not always effective as they had not identified the issues we found during our inspection, detailed previously in this report. For example, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards had not been implemented as they should to ensure people's rights were fully protected. Staff and the registered manager lacked understanding of the MCA and had not received training that reflected current legislation. Freedom of movement around the home had been restricted for everyone living at the home on the basis of potential risks to one person. Care records were not sufficiently detailed to guide staff in all aspects of people's care, although staff knew people so well this had no negative impact on people.

We spoke with the registered manager about why these issues may have occurred. They were open and honest in their appraisal of the situation. They told us the home was small and family orientated. Many of the staff and people living at the service had been together for a number of years and in this context they had fallen behind some aspects of best practice and changes in legislation. They had fallen behind. The registered manager had no existing links with other manager's or resources to enable them to exchange information and ideas about how to foster best practice. They discussed with us how they might begin to build these networks in order to ensure staff practices were up to date and people were supported appropriately. They told us they would seek guidance from the local learning disability team to build more specialist knowledge of supporting people with autism and learning disability. They said they would also begin to attend care manager's forums and bring their own training in MCA up to date as a matter of priority. People's personal profiles would be reviewed and updated to ensure they fully reflected people's needs in line with current practice and legislation.

Relatives of people who lived in the home were complimentary about the service. One relative said "If all homes were like St David's, there would be a lot of happier people in the world". Another relative said "We are so pleased [their relative] lives there".

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. Everyone we spoke with expressed confidence in them. One person said "[Name of manager] is good. She knows what she's doing". A relative said "She runs a tight ship and always answers any queries I have. She's open to improvement and any new ideas". A healthcare professional echoed these comments, saying "[Name of manager] really listens. She's a good manager and there's no resistance to new ideas". Staff told us they liked the way the registered manager led the service. One member of staff said "Her leadership style is relaxed unless someone isn't performing as part of the team. Then she'll step up and deal with it".
Staff appreciated the manager working alongside them, as part of the team. They said the manager was a strong role model and this helped staff develop their learning. They also had a detailed understanding of all aspects of the care needs of people living at St David's and had insight into the challenges staff sometimes faced.

Staff said they felt very motivated and they were all dedicated to ensuring people received the best possible care and support. They said the registered manager was passionate about the service and entirely focused on people's needs. The director of the service said "We are very lucky. [Name of manager] is a very efficient manager and we have enthusiastic and dedicated carers. Everyone is very committed. The staff are all here for the residents". Staff said they worked well together as a very friendly and supportive team. A member of staff said: "We've got a really strong team and we're all eager to learn. It's a brilliant place to work – so rewarding."

Staff confirmed they were able to raise concerns to the registered manager who was always approachable. They agreed any concerns raised were dealt with immediately. They told us the manager encouraged a culture of openness where everyone's view was valued. One member of staff said "We all communicate well as a team. We're honest with each other and can raise any concerns easily". A healthcare professional said "There is an honesty and openness to the service. Staff at St David's don't hide anything. They want to learn and get the best for people".

There was a staffing structure in place with clear lines of reporting and accountability. All experienced staff had designated areas of responsibility. For example, in relation to fire procedures, menu planning and nutrition, activities, medication and health and safety. The registered manager had oversight of all areas and completed regular checks that work was being completed correctly. Staff supervision was provided by the registered manager and deputy. The service provider (the owner of the service) lived nearby and visited St David's regularly. They provided supervision to the registered manager and had oversight of any improvements to the physical environment, including refurbishment and maintenance. The registered manager told us that in the past some of their decisions had been over-ruled by the provider and they had not always felt supported. However, they had been able to discuss this openly and felt this issue had been resolved, leaving them in a positive place to develop the service for the future.

The registered manager knew about the various statutory notifications providers were required to submit but said no notifications had been necessary during the last 12 months. Notifications are significant events that the registered manager needs to notify the Care Quality Commission about. The registered manager was able to tell us confidently about the types of incidents that should be reported, but said there had been no incidents that met this criteria.

People were encouraged to express their views about the service at house meetings or keyworker meetings. Staff said people tended to focus on activities and food choices, but they were always encouraged to think about other subjects too, including any concerns they might have. Relatives and health and social care professionals were encouraged to give their views on the service either directly to the management and staff or through care review meetings. A comments and suggestions questionnaire had been used in the past to gather feedback but the registered manager was reviewing how feedback was sought to encourage participation as the response level was low.

There were systems in place to assess, monitor, and improve the quality and safety of care. A series of audits were undertaken. These audits included looking at medicines, the environment and care plans. One audit of the environment had led to the purchase of new carpets that were being laid at the time of our inspection.

People were supported to be involved in the local community. Staff supported people to go out most days of the week. This ranged from attendance at specialist work placements for people with learning disabilities to a variety of social and leisure activities. Staff told us people at St David's were well known in the local community and were always greeted warmly. Some people were moving towards living more independently and staff told us shop owners and people in the local community would provide assistance and support if

people ever experienced any difficulties.

Records were well maintained and well organised. All records we asked for were kept securely but easily accessible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Action had not been taken to assess people's mental capacity or reach best interest decisions in line with the requirements of the Mental Capacity Act 2005, and code of practice. Deprivation of Liberty safeguards had not been sought where people met the criteria for application. Regulation 11 (1) (3)