The Frances Taylor Foundation

St Joseph's Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 19 November 2018 and was unannounced on the first day.

St Joseph's Care Home is registered to provide residential and personal care for up to 36 people. At the time of the inspection there were 36 people living at the service. The service is a purpose built single story building consisting of three units and provides care to adults with complex physical needs and learning disabilities. The service also operates a day care centre. Each of the three units has its own dining room, lounge and sensory room. There is a pleasant garden area with outdoor seating.

As the service provides care to people with learning disabilities, 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.

St Joseph's is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection a registered manager was in post. A registered manager is a person who has registered with CQC 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.

We last inspected the service on 5 February 2016 when we rated the service as being 'Good.'

At this inspection, we found the service to be in breach of 'Safe, care and treatment' and 'Good governance' which are breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act (Regulated Activities Regulations) 2014. This was because systems in place to manage topical medication, thickening agent, PRN medications (as and when required medication) and controlled drugs were not being properly managed and systems to manage the quality and safety of the service were not always effective.

We found that topical medicines were not managed safely. Topical medicines are medicines which are usually applied to the skin such as creams, gels and ointments.

We also found that the use of thickener in fluids was not recorded on people's fluid input charts. Thickener is a prescribed product and is used to reduce the risk of choking for people with swallowing difficulties.

We looked at the management of PRN medication. We found that for some people who were on PRN medication (such as pain relief), staff had not recorded the time of administration meaning it was not possible to identify whether the correct amount of time had elapsed between doses.

Controlled drugs were not always managed safely. Controlled drugs are subject to the Misuse of Drugs Act and associated regulations and so require extra checks.

We found that for one person with a PEG feed, the care of the PEG had not been recorded on the MAR chart. We spoke to a senior member of staff about this who advised us the care had been carried out but had not been formerly documented.

The service was also in breach of Regulation 17 'Good governance' of the Health and Social Care Act (Regulated Activities Regulations) 2014. This was because systems to manage the quality and safety of the service were not always effective. Although we saw evidence that the service carried out regular audits and had identified issues, it was not always recorded as to what action had been taken and by who. In some instances, action plans had not been implemented to say what actions would be completed.

Some of the medication audits we looked at highlighted medication errors, it was not clear from the audits as to whether action to address those issues had been undertaken. Although medication audits were being carried out, they were not always effective and had not highlighted the concerns we identified during our inspection. You can see what action we asked the provider to take at the back of the full version of this report.

All of the people we spoke with and their relatives told us they felt safe living at St Joseph's. Staff understood their responsibilities in relation to safeguarding people from abuse and mistreatment and were able to explain how they would report any concerns. Any safeguarding concerns which had arisen in the service were acted on in a pro-active way. Provider meetings were held to discuss concerns which helped decrease the risk of any recurrence.

Arrangements were in place with external contractors to ensure the premises were kept safe.

We looked at how accidents and incidents were reported in the service and found they were managed appropriately.

We looked at recruitment processes. We reviewed personnel records for four members of staff. We saw that each staff member's suitability to work at the service had been checked prior to employment to ensure that staff were suitable to work with vulnerable people.

We looked at care records belonging to four people. We saw that people's care requirements were identified and people were appropriately referred to external health professionals when required. This helped to maintain people's health and well-being.

People and their relatives were involved in the formulation of their care plans. We saw that people's preferences were considered. Staff supported people in a person-centred and dignified way.

Staff sought consent from people before providing support. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) to ensure people consented to the care they received. The MCA is legislation which protects the rights of people to make their own decisions.

Many people were supported on a one-one basis and we found there were enough staff on duty to meet people's needs. Interactions we observed between staff and people living at the service were warm and caring. Staff treated people with great respect and took care to maintain people's privacy and independence. Relatives of people living at the service told us that staff were extremely compassionate and

considerate.

There was an open visiting policy for friends and family. The service provided dedicated accommodation for relatives so they could stay overnight to support their loved one if required. This helped both people and their visitors feel supported. Friends and family told us the service actively involved them in the care of their relative and made them feel welcome. For people who did not have anyone to represent them, the service supported them in finding an independent advocacy service to ensure that their views and wishes were considered.

The service operated a day centre for people who did not reside at the service. People living at the service could also utilise the resources at the day centre. Activities included movies, arts and crafts and music.

All meals were home cooked on the premises using fresh ingredients. We spoke to the chef who was knowledgeable about people's preferences and dietary requirements. Innovate methods of cooking and presenting pureed food were utilised which helped to make food more appetising and increased people's independence when eating.

The service had a complaints procedure in place. Complaints were recorded and acted upon appropriately. Relatives told us they would feel comfortable in raising any concerns they had with the manager.

We found the environment to be clean and spacious, this made it easy for people to navigate around. People could decorate their own room so that each room was completely unique to them.

Feedback about the management of the service was positive. Staff told us managers were supportive and promoted an open and transparent culture.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed and administered safely.

Staff were knowledgeable about safeguarding and effective measures were in place to address any concerns which helped keep people safe.

Staff were recruited safely.

Accidents and incidents were reported and recorded appropriately.

Is the service effective?

Good

Principles of the MCA were followed and staff were knowledgeable around the area of mental capacity.

Advice from external health professionals was recorded appropriately in people's care records.

Staff were well supported in their role through training and regular supervisions. Staff had received specialised training to meet people's needs.

Staff were knowledgeable about people's dietary requirements and preferences. Innovate ways of cooking were used for puree diets.

Is the service caring?

Good

The service was caring and compassionate.

Interactions between staff and people living in the home were warm, genuine and positive.

We observed people's privacy and dignity being respected during our inspection.

Family and friends could visit when they chose.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable regarding people's care needs and preferences. People were matched with key workers based on shared characteristics and interests.

The service promoted the delivery of individualised and person-centred care which promoted people's independence.

Innovative systems were in place to gather feedback from people and listen to their views.

Is the service well-led?

Requires Improvement

This service was not always well-led.

The service completed a range of audits in relation to quality and safety, but they had not always been effective in identifying concerns.

There was an extensive set of policies to provide staff with guidance.

Feedback regarding the management of the service was positive.

St Joseph's Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 19 November 2018 and was unannounced on the first day. The inspection was conducted by two adult social care inspectors, an 'Expert by Experience' and a 'Specialist Advisor.' An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service and a specialist advisor is a person who has professional experience and knowledge of the care which is being provided.

Before the inspection we reviewed the information we held about both the service and the service provider. We looked at any statutory notifications received and reviewed any other information we held prior to visiting. A statutory notification is information about significant events which the service is required to send us by law. A Provider Information Return (PIR) was also submitted and reviewed prior to the inspection. This is the form that asks the registered provider to give some key information in relation to the service, what the service does well and what improvements need to be made. We also invited the local authority commissioners to provide us with any information they held about the service. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the deputy manager, four members of care staff, a team leader, a chef, a person who lived at the service and two visiting professionals. Due to their health conditions, most people living at the service were unable to speak with us so we undertook general observations of the service and the care people received. We used a number of different methods to help understand the experiences of people who lived at the home. For example, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help understand the experience of people who could not talk to us. We also spoke to four relatives of people using the service to gain a better understanding about their experiences of care at St Joseph's.

We looked at care records belonging to four of the people living at the home, four staff recruitment files, a

sample of medication administration records, policies and procedures and other documents relevant to the management of the service.

We also undertook general observations of the service over the course of our two-day inspection.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found the registered provider was in breach of 'Safe care and treatment' which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not always manage topical medicines, PRN medication, the use of thickening agent and controlled drugs safely. This meant that people were not always receiving their medication in a safe and proper way.

We found that staff who applied topical medication had not recorded to confirm they had done so. We found that although Medication Administration Records (MARs) were in place for topical medicines, they were not always recorded by the staff who were administering them. This meant that people were at risk of not receiving their topical medication as prescribed and in a safe and appropriate manner.

We saw that topical medicines were left in people's bedrooms which meant they could be accessed by vulnerable people. We spoke to the registered manager about our findings. They immediately implemented recording charts so that staff could appropriately record the application of topical medication. They also confirmed topical medication would be stored in a secure location.

We also found the administration of PRN medicines was not recorded accurately. This meant it was not possible to ascertain times of administration and determine if the correct amount of time had elapsed between doses. This is important as some PRN medications, such as painkillers, require a minimum period between doses. We spoke to the registered manager about this.

We looked at how thickening agent was managed and found that its use was not always recorded appropriately. Although staff were aware of how much thickener to add to people's fluids, the use of thickener was not being recorded on people's fluid input charts. We also saw that instructions for its use (such as the quantity required to add to fluids) was not always recorded on people's MAR charts. This meant that people were at risk of receiving fluids which were not at the correct consistency. This is important as thickening agent is prescribed for people with swallowing difficulties to prevent them from choking. By the end of our inspection, the registered manager had amended the current fluid input charts to enable care staff to correctly record the use of thickener.

We looked at how controlled drugs were handled and found that staff did not always comply with legislation and the registered provider's medication policy in place around controlled drugs. Controlled drugs are subject to the Misuse of Drugs Act and so require extra checks. We found that the quantity of controlled drugs was not always recorded effectively, this made it difficult to locate the amount of some controlled drugs within the service. The return of controlled drugs back to the dispensing pharmacy was not practised in a safe way. We were unable to locate any records to confirm the type and quantity of controlled drug being returned. We also found that controlled drugs had not always been signed out on the controlled drugs register book, this meant that although records showed the drug in stock, the controlled drugs cupboard did not always contain the drug. We found that the transfer of controlled drugs between units within the service was not being properly recorded meaning that some controlled drugs could not be located. We spoke to the

registered manager about our concerns and findings.

We looked at MAR charts and saw that although some people's medication was required to be given before breakfast, it wasn't always possible to determine if this had been done as administration times on people's MARs stated only morning or breakfast.

We saw that care of people's PEG (Percutaneous Endoscopic Gastrostomy) was not always documented in care records. We spoke to senior staff about this who confirmed that although the care had been carried it out, it had not been documented and recorded. This made records inaccurate and unreliable. PEG feeding is when a tube is surgically inserted into the stomach and provides a means of nutrition and hydration for people unable to tolerate food and fluid by oral means.

We found that medicines were stored safely. Medication on all three units were stored in a locked clinic room which was kept clean and tidy. The clinic room was of adequate size and had hand washing facilities. The temperature of the room and medication fridge were recorded daily to ensure they were within a safe limit. This is important as if medication is not stored at the correct temperature it may not work as effectively.

We saw that some people had covert medication plans in place so that medicines were disguised in food or drink without their knowledge. This meant that although the person refused their medication, it was vital to their well-being. We saw that this decision had been made with the input from the GP and pharmacist and had been made in accordance with the person's best interests.

A medicine policy was in place to advise staff on the registered provider's medication policy procedures. Nationally recognised best guidance on the administration of medication was also available.

Not everyone was able to verbally communicate their views so we spoke to relatives of people who told us they felt safe living at the service, comments included, ''They make me feel [relative] is safe because they contact me, I do not have to worry when I am away" and ''[Relative] is safe and secure here, the staff make sure of that.''

We looked at how the service was staffed. Due to the complexity of people's health care needs, care was provided on a one to one basis for most people. We looked at staffing rotas for the past four weeks and found there were enough staff to meet people's needs. On some occasions the service used agency staff but were careful to request staff who had visited the service previously. This provided continuity of care and meant that agency staff were familiar to people and their needs.

We looked at how staff were recruited within the service. We looked at four staff personnel records and saw that appropriate checks had been carried out to ensure they were safe to work with vulnerable people. We also saw that previous employer references had been obtained prior to employment and criminal conviction checks had been made.

We spoke to staff to check their understanding of safeguarding people from abuse, maltreatment and neglect. Training records showed that staff had received training in this area and staff we spoke with were aware of the procedures to follow regarding any suspicion of abuse. Staff told us they would not hesitate to report any concerns or signs of mistreatment or abuse. One staff member told us, ''I would tell the person in charge if I suspected anything. If I still wasn't happy I would take it externally.''

We looked at safeguarding records for events which had occurred in the service. We saw that each event was

analysed. The registered manager told us that all managers from the registered provider's services met quarterly to discuss best practice and how to manage safeguarding events going forward. This was a pro-active process and helped the service deliver safer care and mitigate any risk of reoccurrence of past events.

We looked at four care files which showed evidence of a wide range of risk assessments and tools used to help keep people safe. Care files included individual risk assessments for areas such as moving and handling, falls, choking, behavioural and nutritional risks. Assessments were regularly reviewed to help ensure that people were kept safe and risks to people were kept to a minimum.

Staff had access to personal protective equipment (PPE). This is equipment used to help reduce the spread of infection. Regular audits were carried out in relation to infection control measures and any issues of concern were identified and acted on. The service employed domestic staff to oversee the cleaning and feedback from people's relatives about the cleanliness of the service was positive. During our inspection we observed the service to be clean, uncluttered and well-maintained.

We looked at systems in place for monitoring environmental risks in the service. Firefighting equipment was maintained and people had a personal emergency evacuation plan (PEEP) in place. This meant that staff and emergency personnel had important information on people's needs and the support they required to evacuate in the event of an emergency.

External contracts were in place for gas, electric, fire safety and legionella. Records also confirmed that gas and electric appliances had been tested and were compliant. Additional checks and audits were completed such as water temperature, automatic door closure devices, fire alarms and call bells. The service employed a maintenance person to help maintain the internal and external parts of the service.

We looked at accidents and incident reporting within the service and found they were recorded in sufficient detail and managed appropriately. The registered manager analysed records on a monthly basis to help identify any trends or patterns. This helped to further improve people's safety, for example, by implementing changes to people's care plans and risk assessments to reduce the risk of reoccurrence.

Communication within the service was good. Staff had daily handovers during which any accidents, incidents and the health status of people were discussed. Care staff recorded daily notes and there were communication books for all units so that staff were kept up to date with people's current needs. Team leaders from each unit met also with the management on a daily basis for a handover. This helped to ensure safe practices.

Good

Is the service effective?

Our findings

We looked at the care records for four people. Records showed care plans which reflected both the health care needs of the person in addition to their personal preferences. For example, people could choose whether to have a bath, shower or a body wash and choose the gender of their care staff.

Care records also contained a detailed pre-admission review so that people's key health care requirements were identified and could be met from the time they arrived at the service. Care records contained detailed guidance for staff on how best to emotionally support and communicate with people. This was particularly important as most of the people living at the service had complex health care needs and were unable to communicate verbally. A member of staff told us, ''We get to know every facial expression and people's body language.'' It was clear that staff knew the people they were caring for well, a relative told us, "They know [relative] well, they love them, they are part of their family."

We saw that people were referred to external health care professionals appropriately, this included the GP, speech and language therapists (SALT), opticians, podiatrists, district nurses, physiotherapists and occupational therapists. The service had strong links with both a local GP surgery and pharmacy. This ensured that people's health needs were met by professionals who knew them well, this helped to preserve their overall wellbeing. Comments from relatives included, "The support is immense; St Josephs has a very good relationship with Southport A&E" and "A nurse visits every Monday and Wednesday.'' We spoke to a visiting health professional who told us, ''The staff are responsive and efficient, communication is good and our advice is followed through.''

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 had the appropriate legal authority and were being met. We looked at people's care records and saw evidence that people's capacity to consent was assessed appropriately in relation to a range of decisions. 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We looked at the records for four people who had DoLS authorisations in place. We found there was an effective process to record any restrictions in the best interests of people living at the home. For example, we saw evidence that best interest meetings had taken place in relation to medical intervention and treatment, for example, annual flu vaccinations, and that any intervention carried out by staff was done to benefit the person. There was also evidence of best interest decisions being made with input from people's relatives. For other people, we saw evidence of relatives having the appropriate legal status to make important decisions on behalf of their relative living at the service, such as consent to treatment and medical care.

Care records we looked at contained information on how staff supported people with their dietary needs, for example, a diabetic diet. Records also demonstrated that people were weighed regularly to ensure that people were not losing or gaining weight inappropriately. Both care and kitchen staff we spoke with were aware of people's individual dietary requirements.

All meals were home cooked on the premises. There was a menu displayed in the dining room of each unit. On the first day of our inspection we saw evidence of one choice for a main meal. We spoke to the chef about this who told us that if the person didn't like what was on the menu, they would be made an alternative of their choice.

Most people were unable to provide verbal feedback about the food but a relative told us, ''The food is excellent; the quality is good.'' We observed lunch time in the dining room and saw that people who required assistance were provided with this in a dignified manner. Each person had their own personalised placemat. The placemat contained a photograph of the person and key information such as what assistance they required at mealtimes, details of any specialised diets, instructions on how they took their fluids and any adapted crockery and cutlery they required or preferred. This helped people receive the support they required as many were unable to verbally communicate their needs and preferences to staff. This helped to ensure dignity and personalised care during mealtimes. Placemats were put away after mealtimes to maintain confidentiality.

We also observed that for people requiring a soft diet, food was pureed to the correct consistency for the person and moulded so that it represented food in its original form. The presentation of the food made it more appetising for people in terms of sight, taste and texture. We spent time talking to the chef who told us they had received specialised training in the preparation of pureed foods. Some foods could be moulded to resemble the original food and its texture and picked up and eaten as a finger food. This helped to promote people's independence during mealtimes in addition to making eating a far more enjoyable experience.

Records showed that staff members received regular supervisions to support then in their job role. Supervision enables management to monitor staff performance and address any performance related issues. In addition to their professional development, we saw that the registered manager also encouraged staff to discuss issues they felt important to them both personally and professionally. This ensured that staff were kept up to date with current guidance and good practice. Staff also told us it had a positive effect on their well-being.

The registered manager provided us with information on staff training. We saw that training was provided in a range of health and social care topics such as moving and handling, fire safety, first aid, safeguarding and cardio pulmonary resuscitation (CPR). Some staff had received training in more specialist areas such as dementia care and postural care. Most staff had completed external courses in care such as National Vocational Qualifications (NVQs). These qualifications were funded and encouraged by the service. NVQs are work based qualifications which recognises the skills and knowledge a person requires to do a job helping them to carry out the tasks associated with their job role.

Although all staff had completed mandatory training, a number of staff had not updated this training. We discussed this with the registered manager who provided evidence to confirm that gaps in training had already been identified and refresher training had been organised. A revised training matrix was presented to us on the second day of our inspection.

Induction training for staff was based on the Care Certificate. The Care Certificate was introduced by the Government in 2015. This is a set of standards that social care and health workers comply with in their daily

working life. We noted that the service invested in training its own staff to become trainers to help make training more accessible and bespoke to the needs of the people living at the service, for example, postural care. This training educated staff about the importance of positioning people correctly as many of the people living at St Joseph's were unable to mobilise independently. The training was important for people's comfort and safety and maintaining good pressure area care. A member of staff explained, ''It's about so much more than positioning people in the right way, it's about breathing easier and improved posture.''

The service also worked alongside visiting physiotherapists who trained staff to carry out chest physiotherapy, this helped reduce the risk of chest infections and reduced the risk of people needing to be admitted to hospital. For one person, staff had trained in a specific medical procedure so that they had the knowledge and skills to treat a person's specific condition which often led to the person being admitted to hospital. Because staff could carry out the specialised procedure themselves, this had significantly decreased the person's need to attend hospital.

The service invested in training up its own members of staff rather than outsourcing it to external suppliers. This enabled the service to tailor training to meet the individualised needs of the people living at the service. The service actively sourced and invested in training which would directly benefit the needs of people, for example, sensory therapy. This interaction was used for people when they were feeling agitated or distressed and helped to make the person feel calm and reassured.

The service also promoted staff to become champions of themes such as safeguarding, dignity, palliative care and dementia. These staff members acted as a source of information and education for other staff members and helped to promote best practice within the service.

People we spoke with felt that staff had the knowledge and skills to meet their needs, comments from relatives included, ''Staff are well trained to meet [relative's] needs. Staff have undergone additional training to support [relative's] needs and to keep them out of hospital'' and ''This is a real centre of excellence.''

During our inspection we looked at people's bedrooms and saw evidence that people had personalised them. For example, some people had brought in their own items of furniture, others had family pictures on the walls. All bedrooms had had an en-suite facility. People could choose their own wall paper, furniture, paint colour and bedding. Staff supported people with shopping trips to purchase items for their rooms. This helped people feel a real sense of belonging and that St Joseph's was their home.

The service was registered to provide care for people with a learning disability. This meant it had a duty under 'Registering the Right Support' Regulations to ensure that, wherever possible, people had the freedom and choice to transfer into supported living accommodation within the community. Although people living at the service had the choice to move on, many had highly complex physical, psychological and emotional needs which would render them vulnerable and unsafe living in a community setting. Given the severity and complexity of their needs, most of the people living at the service were supported on a one to one basis. We were able to communicate with a long-standing resident at the service who communicated to us that he was happy and content living at the service. All the relatives we spoke with were happy with the care provided and felt that St Joseph's was a long-term home for their loved one.

The service was based on one level and so was easy for people to move around. We found the environment clean and uncluttered. The service offered a sensory hydro pool and a large conservatory. The hydro pool had mood lighting and sensory equipment and was operated by specially trained members of staff. Many people used the hydro pool which not only provided therapeutic and physical benefit but was a great source of sensory stimulation. In addition, there were sensory rooms located on each unit which included light and

music stimulation and a warm water bed. Staff told us that many people enjoyed visiting the sensory rooms as they found them relaxing and calming.

The service had a pleasant and enclosed outdoor space which people assessed in the summer months. Comments from relatives included, "[Relative] loves the water and the pool, it's a god-send, they love the jacuzzi bath and the sensory room" and "The grounds are lovely, [relative] enjoys the music activities and has the choice to access the resource centre."

Good

Is the service caring?

Our findings

Most of the people living at the service were unable to talk to us but their relatives told us they were highly satisfied with the service and how well staff cared for them. Comments from relatives included, "You could not get better tender loving care, they are very committed," "They are very caring, most definitely, I can leave here with absolute confidence,'' ''I am very happy with the service, [relative] is happy, there was nowhere else suitable until [relative] came here" and ''It has been heaven sent, it's wonderful and you can see it's a place where [relative] will be safe and happy.''

We observed positive and warm interactions between staff and people living at home. It was clear there were genuine and strong bonds between staff and the people they were caring for. People were treated respectfully and in a manner both appropriate for their needs and level of independence. Staff were patient and kind and showed great empathy. We observed the delivery of care at various points throughout the day. We saw people were comfortable and relaxed with staff and it was evident staff knew the needs and preferences of the people they were caring for well. Staff took time to explain what they were doing before any intervention and spoke to people using their names. They took every opportunity to talk and interact with people and engaged in physical contact such as placing their arm around shoulders and holding hands to provide people with reassurance. A member of staff told us, ''We are all here to give good care, that's why we come in every day.''

The service operated a 'key worker system.' Staff were matched with people they supported based on their personalities, shared characteristics and interests. This helped staff to build good relationships with the people they supported. This helped to ensure people received personalised care and support dependent upon their preferences. A member of staff told us, ''This [key worker system] helps us to build a great rapport with the people we support.''

We observed staff supporting people in a way that maintained their privacy, dignity and independence and took care to adhere to people's routines and personal preferences. We observed staff closing people's bathroom and bedroom doors when delivering personal care.

During our inspection we made observations during lunch. Most people ate in the main dining room. There was a menu on display and food was nicely presented. Most people were being assisted by staff to eat. This was done in a patient manner and staff members chatted and interacted with the person throughout the meal.

Care records we looked at provided information on the most effective ways for staff to communicate with people, for example, 'staff to speak slowly,' 'make eye contact' and 'to provide instructions in a quiet environment.'

Each of the people living at the service had a 'Making It Happen' portfolio. This was pivotal in enriching the lives of people and in the deliverance of person centred care. This type of care focused on interaction between staff and people based on their preferences, routines and activities they had an interest in

participating in and which were meaningful to them. This method of care underpinned the ideology and mission statement of the service which was the deliverance of highly personalised, dignified and individualised care. One member of staff told us, ''We put the person at the heart of everything we do, and that is what 'Making it Happen' is all about.''

We saw that the service adhered to the principles of the Equality Act 2010. This is legislation designed to preserve people's protected characteristics such as age, disability, sexuality, culture and religion. One person was unable to verbally communicate and instead used a 'communication board' to communicate with staff. The person also used hand gestures to communicate. These methods of communication were innovative and ensured the person's inner voice was heard. The person accessed the community independently as they carried a call bell and could call for assistance when outside. This helped to promote the person's independence and sense of freedom.

We asked staff what equality and dignity meant to them, one member of staff told us, ''Everyone is their own person, they are all different and we treat them as so.''

The service had an open visiting policy so that relatives and friends could visit at any time. All relatives we spoke with told us they were always offered refreshments and were warmly welcomed when they entered the service. One relative told us, "I am made very welcome, I am offered coffee and toast. I am invited to the Summer Fayre and Christmas events." Friends and relatives were also able to stay overnight in designated accommodation to support their relative if required.

Staff also supported people who were admitted to hospital. They provided 24-hour care whilst the person was in hospital. This provided continuity of care for the person rather than being supported by hospital staff who were unfamiliar to them.

For people who had no family or friends to speak on their behalf, the service had details of an independent advocacy service. An advocate helps to ensure that the views and wishes of the person are conveyed. A member of staff told us, ''We would always take steps to ensure that the person's voice is heard.''

People's care records were kept in locked filing cabinets in the office so that confidentiality was maintained.

Good

Is the service responsive?

Our findings

We looked at the care records of four people who lived at the service and found that people's preferences in relation to how their care was delivered was recorded. For example, people could specify what time they liked to get up and go to bed and what gender of care staff they preferred. This provided staff with information regarding the extent people wished to be involved with their care and treatment. Care records gave staff the information as to what people could do for themselves and what assistance they required.

Care records contained one-page profiles which provided key information about the person such as their preferred name, how to support them when they were distressed or sad, what made them happy, how best to communicate with them and what activities they liked to do. These documents helped staff get to know the people they cared for and provide care based on people's individual likes and dislikes. It was evident from some care records that people's relatives had been involved in providing this information. A relative told us, "They know[relative] well, they know [relative's] likes and dislikes, they are very good with [relative]." The registered manager told us the service went to great lengths to actively involve family members as they knew their loved one best, what they liked and what they didn't like. A staff member told us, "They [relatives] are the ones who tell us the information we need to help look after their loved one."

Care records were maintained by staff who reviewed each person's care daily. Some relatives we spoke with were involved in decisions about their relative's care. One told us, "If there are any changes I am called right away so I know about it."

The service celebrated commemorative days and holidays such as Valentine's Day, Easter, Halloween and Christmas. The service strongly believed that family members should be involved and took every opportunity to invite them to events. For example, at Christmas, the staff cooked a Christmas dinner for the families of the people they supported and invited them to their staff party. Staff also supported family members to take their loved on away on holiday. One person had enjoyed a holiday abroad to Spain with their family member. This was a dream come true for both parties. This not only helped relatives feel supported by staff but also helped to maintain strong bonds with their relatives.

The service had good links with the local community and attended as many events within the community as possible. This helped people to feel a sense of belonging and inclusion. Comments from relatives included, "They have taken [relative] out shopping and for meals in Liverpool, they went on holiday to Blackpool to an adapted property" and "[Relative] was supported to access the lounge and mix with the others even when they were poorly." A member of staff told us, "If people are presenting as bored, agitated or low mood they can go out if they wish, we use public transport, the train service is fantastic." A visiting professional commented, "Even though people are vastly compromised they don't miss out, I'm amazed at what they achieve here."

People had access to a complaints procedure and relatives we spoke with knew how to make a complaint. A relative who made a complaint in the past told us, "They always listen, they are never defensive, they investigated and resolved the issue." The registered manager maintained a record of any complaints

received and the actions taken to resolve them. All relatives we spoke with told us they would raise concerns without hesitation. We noted that the service was particularly pro-active and worked collaboratively to address any complaints made by family members. For example, by inviting the family member to staff meetings so they could see first-hand the action taken to address their complaint and reach a resolution they were satisfied with. This also helped staff to understand the reasons for any complaint made in the first place and so was both an effective learning exercise and tool to drive improvement in both quality and service.

We looked at processes in place to gather feedback from people and listen to their views. We saw that the service used innovative ways to seek feedback from both people using the service and their relatives. Feedback included quality assurance surveys in the form of questionnaires and both resident and relative meetings. Questionnaires for people living at the service were individually formatted in such a way to help them understand the questions easier. The service had invested a lot of time in outsourcing the development of the surveys to an independent local organisation. This entailed people with learning disabilities visiting the home and spending time with people to gage their views, opinions and aspirations. This meant that quality assurance systems had credibility and meaning and were as effective as possible in gaining the real opinion of the people living at the service. This gave people a voice and allowed them to have a say in the running of the service.

Records showed that regular meetings took place with people living in the service and their relatives. The trustees of the service also attended and a buffet lunch was provided. Minutes of meetings were sent out for any relatives who were unable to attend. We saw that a wide range of topics were discussed such as activities, meals, what was working well and what not so well, recruitment of staff and holidays. Relatives were also provided with a monthly newsletter which was bespoke to them and provided them with a summary of care for their relative for that month. The newsletter included photographs and information about any activities and health appointments.

We noticed that there was not a formal way of gathering feedback from visiting healthcare professionals. We discussed the potential benefits of this with the registered manager.

We saw evidence that the service supported people with End of Life Care. We noted people's end of life wishes recorded in their care files and that family members had an active role in supporting the person. For example, one person had specified that they wished to remain at St Joseph's and did not want to go into hospital. A relative told us, "I credit the home with extending [relative's] life for at least 13 months and keeping them here." The deputy manager told us that people at the end of their life were never left alone, there was always a member of staff who the person knew well to sit with them. The service also supported families by providing them with accommodation on site to enable them to stay overnight and provide ongoing support to their loved one. A relative told us, "They go that extra mile."

Requires Improvement

Is the service well-led?

Our findings

During our inspection we saw that audits were in place with regards to the safety of the environment, fire safety, infection control, care plans, accidents and incidents and medication. Audits we reviewed were up to date but were not always effective as they did not always identify areas where improvements were required. Audits had not identified areas of concern which we highlighted during our inspection. We also observed that where audits had highlighted issues, there was not always a record of any action having taken place to address this.

Medication audits had not identified our concerns in relation to the administration of topical medicines, PRN medication, the use of thickener in fluids and the management of controlled drugs. We spoke to the registered manager about this. They told us they were in the process of organising a pharmacy visit to provide support, advice and further training with medication management.

Audits regarding people's daily progress notes also identified some issues with recording by staff but it was not always clear as what action had been implemented to rectify this. There was often no evidence of any timescale or person responsible for actions.

This was a breach of 'Good governance' Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's feedback about the management of the service was positive. People we spoke with told us the registered manager was open, transparent and approachable and they felt able to raise any issues or concerns with them. Comments from staff included, ''They [management] not only look after the people living here and their families but also take care of the staff and that really makes a difference,'' ''The management are amazing'' and ''They [managers] always listen and give good advice and support.''

Relatives we spoke with also spoke positively about the registered manager, comments included, "I am reassured because [relative] always has lovely smile when the manager appears," "I can phone and speak to the manager anytime,'' ''[Manager] is very good, very approachable, communication is good, we get contact via telephone and email," "They are good leaders, staff respond well to them, I would recommend the home without hesitation, we are very grateful" and "The home has improved remarkably since both managers took over, they encourage staff to improve."

During our inspection, the registered manager was receptive to our feedback and highly responsive to our findings. By the end of our inspection they had produced an action plan specifying what action they planned to take to address the issues we had found. The management were clearly passionate and had a clear vision on what improvements they wanted to make to enhance the quality of life for people living at the service. The registered manager told us, ''The people here are at the heart at everything we do, it's why we are here.''

There were regular staff meetings which enabled staff to share their views and opinions. We looked at a

selection of minutes of meetings which showed topics discussed included training, safeguarding, accidents and incidents, complaints and compliments. It was evident that best practice was promoted during these meetings and staff were encouraged to develop the service further, for example, by learning lessons from things that had gone wrong in the past.

Staff we spoke to were keen to tell us that the ethos and culture of the service was implemented through the care being provided and that compassion and dignity were the cornerstones of St Joseph's. One member of staff told us, ''That comes all the way from the management and down.'' The deputy manager told us that the 'Making it happen' approach was integral to the service's way of working that encapsulates the mission statement of the Francis Taylor Foundation (the registered provider). They told us, ''We support our staff to give people the best life possible.'' A member of staff told us, ''It's a brilliant idea, like nothing I have ever seen before.''

There was a wide range of policies and procedures in place to guide staff in their roles. Topics included safeguarding, equality and diversity, infection control, whistleblowing, dignity and privacy, medication and end of life care. Staff we spoke with were aware of the home's whistleblowing policy and told us that they would not hesitate to raise any issues they had. Having a whistleblowing policy helps to promote an open and transparent culture within the service.

The registered manager also told us they practiced a flexible working policy for staff which helped promote their well-being, for example, by arranging shift patterns around childcare arrangements and health appointments, ''We find that if we look after our staff well they will look after the people well.'' It was evident that staff enjoyed their roles, a member of staff told us, ''It's an amazing place and I am grateful to work here.''

The registered manager had notified CQC of any events that had occurred in the home in accordance with our registration requirements. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last inspection were displayed within the home as required. The registered provider's website also reflected the current rating for the service. From April 2015 it is a legal requirement for registered providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines and controlled drugs were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit processes did not always identify concerns relating to the management of medicines. This meant that risk to people was not always monitored and mitigated.