Voyage 1 Limited

The Grange, Liss

Inspection report

Farnham Road
Liss
Hampshire
GU33 6JE

Tel: 01730895590
Website: www.voyagecare.com

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection was carried out on 8 and 9 March 2016 and was unannounced.

The Grange, Liss provides accommodation and nursing care for up to 15 people with a learning disability. At the time of our inspection there were 15 people living in the home, 14 in the main house and one in a separate bungalow. The home has a hydrotherapy pool.

The Grange, Liss has a registered manager in post. 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.

There were enough staff to meet the needs of people using the service. We made a recommendation in relation to the effective deployment of staff to ensure people were full engaged.
A recent staff restructuring had taken place which had resulted in improvements but further improvements were needed.

People were protected from the risks of potential abuse. Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. They also knew how to report abuse.

Risk assessments were in place for each person on an individual basis. Clear guidance was recorded for staff in order to mitigate any identified risks. Staff acted on the guidance to protect people from the risks of potential harm.

The provider ensured staff were safely recruited to meet people's needs by carrying out appropriate checks.

Medicines were administered safely by staff who had been trained to do so. Nurses were assessed annually in relation to their competency to administer medicines. Medicines were stored, managed, administered and disposed of safely.

Staff had received appropriate training to deliver the care and support for people living in the home. Staff had regular supervision meetings and annual appraisals and said they felt supported.

People were asked for consent before care and support was provided. Communication support plans made it clear how people communicated so that staff understood when people were consenting. Staff told us that if someone communicated 'no' they would respect this and offer the person support at a later time.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). For example there were mental capacity assessments and best interest decisions for one person around their decision to live at The Grange and their decision to have an

influenza vaccination. Relevant DoLS applications had been submitted for people to ensure that any restrictions were proportionate and in the person's best interests.

A food tasting session was used to determine people's likes and dislikes. Two main choices and a dessert were offered at lunchtime and a hot meal at tea time was available. People's specific dietary needs in relation to their religious beliefs and health conditions were catered for. People using the service had very specific requirements in terms of the consistency of the food they required. The chef had records of these in the kitchen which matched with the requirements recorded in people's support plans and with the type of food we observed them to eat. People were supported to have enough to eat and maintain a balanced diet.

Health professionals were appropriately involved in people's care. People had complex conditions and needed support from a variety of health professionals. Each person had a health action plan which recorded the support required and the outcomes of any visits.

Staff were supportive and caring. The registered manager in particular was observed to interact in a positive way with people, acutely aware of people's individual needs she approached them in individual ways which people clearly loved and responded to. Other staff were observed to respond individually to people, for example by cheering people up when they were in a bad mood.

People's rooms were decorated in a personalised way. These included cushions with photographs of family members on them, photographs which were important to people, cuddly toys, flowers and butterflies. People were supported to maintain close relationships with their family and friends.

Due to their complex needs people were not able to actively participate in their support plan. The level of involvement in support plans was recorded in people's individual plans and was mostly in relation to observing the person and their reactions.

Staff explained how they respected people's dignity by knocking on their bedroom doors before entering. Staff treated people in a dignified and respectful way and addressed them with their preferred names. People were spoken to and about with affection. Everyone was dressed respectfully with freshly laundered clothes which were matching. People were supported to be as independent as possible.

Support plans were included a range of documents to describe people's needs. There were personalised, up to date and aligned with best practice. Support plans provided guidance for staff on what was important 'to' and important 'for' the person and included people's decision making and communication needs.

People took part in a variety of activities and photographs of these activities were displayed throughout the home. Activities included swimming, sailing, going on a train, going to a music festival and the Goodwood festival of speed. People also took regular holidays which included taking part in a variety of activities. Everyone had their own activities plan which was in easy read format so that people knew what they were doing and could look forward to their activities.

The provider listened and responded to feedback about people's experiences, concerns and complaints. The complaints book included only one formal written complaint which had been appropriately dealt with in a timely manner by the registered manager. Relatives told us they found the registered manager approachable and responsive to their concerns. Feedback was sought from staff, relatives and people and appropriately responded to.

There was an open and transparent culture within the home. Staff were able to raise any issues or concerns

with the manager who, they told us, always listened and responded. Relatives told us they had a good relationship with the registered manager whom they respected. They were positive about her leadership of the home.

Staff told us they were aware of their roles and responsibilities, as these had been discussed in a recent team meeting, following the recent staff restructuring. New roles had been developed in order to encourage staff to take ownership of the development of the home and the service.

The registered manager submitted relevant notifications to the Care Quality Commission (CQC) in a timely way. A notification is an important event which the provider is required to tell us about.

The registered manager was aware of the provider's vision and values, which included, passion for care and positive energy. She felt these values were reflected through the passion of her staff to make a positive difference in people's lives.

Checks were undertaken to ensure the quality of the service and quarterly and annual audits took place to drive through improvements.

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 mostly safe.

There were enough staff to meet people's assessed needs, however staff were not always efficiently deployed to ensure that people were kept engaged and received a continuity of care.

Staff knew how to keep people safe from harm and protect them from abuse.

Identified risks had been recorded and addressed.

Medicines were administered safely by staff who had been trained to do so.

Is the service effective?

Good

The service was effective.

People received care and support from staff who had been appropriately trained and who had a detailed knowledge about people's needs.

People were supported to make their own decisions but where they did not have capacity the provider had complied with the requirements of the Mental Capacity Act 2005.

Appropriate DoLS applications had been made to ensure restrictions were proportionate and in a person's best interests.

People were supported to have enough to eat and maintain a balanced diet.

Health professionals were appropriately involved in people's care.

Is the service caring?

Good

The service was caring.

People were supported in a stable and caring environment.

The staff promoted an atmosphere which was kind and friendly.

People were treated with respect and dignity and independence was promoted wherever possible.

Is the service responsive?

Good

The service was responsive.

Care was personalised and responsive to people's needs.

People were supported to take part in activities of their choice.

The provider responded to feedback from people, relatives and staff appropriately.

Is the service well-led?

Good

The service was well led.

We found the home had an open and transparent culture.

The registered manager provided visible and positive leadership to the home, motivating staff to strive for change.

Quality assurance systems were in place to ensure the quality of the service was maintained.

The Grange, Liss

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 was carried out on 8 and 9 March 2016 and was unannounced. The inspection was carried out by an inspector and a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge. In this case their skills and knowledge were in relation to learning disability nursing.

Before the inspection, we reviewed all the information we held about the home including the previous inspection reports and notifications received by the Care Quality commission. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service.

During our inspection we observed and interacted with seven people using the service. We spoke with four of their relatives and friends. We also spoke with the registered manager, the operations manager, a nurse (who was the deputy manager), the chef and three support staff. We reviewed records relating to the management of the home, such as audits, and reviewed three staff records. We also reviewed records relating to six people's care and support such as their support plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation.

We last inspected the home in June 2014 and found no concerns.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us their family members felt safe. One relative, when asked if their relative felt safe, said "Yes, definitely, it's his home now." Another relative said "I do feel he feels safe." People behaved in a way which showed they felt safe and they smiled and interacted with staff.

The registered manager explained how staffing was allocated based on the funded assessed needs of people. For example some people were funded for one to one support for certain times of the day and night. In addition to this the service was staffed on the ratio of one member of staff per two people. On the day of the inspection there were 11 support workers and one nurse working in the home. In order to ensure that people were able to access the community and take part in activities staffing had recently been restructured in the home. The registered manager had appointed two team leaders to take more responsibility for the organisation of staff 'on the floor.' Feedback from staff indicated that the new structure had improved the organisation of staff as it took into account what activities were planned for the day and how many staff were required to support those activities.

During our inspection we found that staff were not always deployed in the most efficient way and there were some areas for improvement. For example, during an observed music therapy session we noticed that not all staff involved themselves in the session and interacted with people. At one point during the session all support staff left the room leaving the music therapist and the housekeeper responsible for the five people taking part in the session. People would have benefitted from the interaction of staff during the session. Swimming was the planned activity for the afternoon. The planned swimming session did not take place until 6pm. This was because people needed extra support when using the swimming pool and so staff in the home needed to wait for staff supporting other activities to return to the home. This meant that people were not engaged in planned activities during the afternoon but were waiting for staff to return to the home so that planned activities could take place. One person was observed receiving a hand massage, however other people were not actively engaged by staff during this time. The impact on people was that they were not engaged in activities at the times planned and spent time waiting for staff to be available.

Lunchtime was a disjointed event for people. One person was supported to eat exactly as their care plan described with a member of staff sat next to them maintaining eye contact. It was not physically possible for everyone to sit round the dining table together. Lunch time was observed to be a job which needed to be done rather than a pleasant social event for people. Some people were supported to eat whilst they were sitting on the sofa. Some people were waiting for their turn wandering around the room, as they required support to eat and staff were all busy supporting others. Another person was sat in a chair which wasn't at the main table and was supported by a member of staff who was standing up. Lunch started at 12.30pm, people were not offered pudding until 2.20pm. This made mealtime much longer than it needed to be. Everyone received their lunch and took part in an activity and there were enough staff to meet people's needs. However, it was the allocation of staff and the interaction with people to ensure they were fully engaged which required improvement. The impact on people was that lunch time was disjointed and people waited nearly two hours to receive all of their meal.

Staff had received safeguarding training and were able to describe types and signs of abuse and potential harm. Staff were aware of the safeguarding policy and had easy access to it. They knew where to find relevant telephone numbers and procedures and how to report a safeguarding concern. Staff were aware of how to protect people from abuse. The registered manager ensured that staff knew about the safeguarding and whistleblowing policies. Cards were handed out to staff entitled 'See something, say something' and the provider had recently produced a new poster about whistleblowing which was displayed on the noticeboard. The cards and poster gave clear instructions to staff about how to report any concerns about the service. Staff said they would feel able to whistle-blow, if necessary, without fear of reprisal. One member of staff had recently reported concerns to the registered manager demonstrating that staff knew how to report concerns and felt able to do so.

Risk assessments, referred to by the provider as support guidelines, were in place for each person on an individual basis. People using the service were living with a learning disability, had complex needs and required nursing care. This meant that people were living with risks such as of choking or of seizures. Many everyday activities also carried risk. The support guidelines described how the person was involved in developing the guideline and the skills they had to contribute to this. Risk rating definitions were categorised as 'stop', 'think', or 'go.' A categorisation of 'stop' required a risk consideration meeting with the wider support team and a 'think' required a risk consideration meeting with the immediate support team. Support guidelines clearly described to staff how the risk should be mitigated to keep people safe and included a summary of critical information. This meant that new or agency staff would be quickly aware of how to keep people safe. The critical information summary advised staff what to always do, what not to do and what to never do. For example a critical information summary for someone at risk of choking stated 'always cut food into bite size pieces, do not rush (the person) and never leave (the person) unsupported when eating.' People were protected from risks and actions had been taken to prevent potential harm.

Generic risk assessments were in place. These addressed risks in relation to the home for staff and visitors. Similarly these were classified as red (stop); amber (think) and green (go). Actions had been put in place to mitigate risks such as those associated with blood born viruses, use of bathrooms and wet rooms and access to dangerous areas. Risks in relation to the hydrotherapy pool had been assessed and appropriate actions taken to mitigate any identified risks.

Incidents and accidents were recorded appropriately and investigated where necessary. For example one person had swallowed a disposable glove. This had resulted in a full investigation, discussion at team meetings and self-reflection. Learning and changes to support plans or support guidelines had been discussed and staff were fully aware of how to prevent any further incidents. This meant the provider took action to reduce the risk of further incidents and accidents.

There was a recruitment policy in place. Disclosure and Barring (DBS) checks were carried out before anyone could be recruited. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Potential staff had to provide two references and a full employment history. The provider ensured staff were safely recruited to meet people's needs.

Medicines were administered safely by staff who had been trained to do so. Medicines were administered by trained nurses, however all staff had undertaken training in medicines administration. Some staff had also received epilepsy training in order to administer emergency medicines in relation to seizures. This ensured they were able to administer emergency medicine at any time when a nurse wasn't present, such as when a person was accessing the community. Nurses were assessed annually in relation to their competency to administer medicines. The check included questions about the provider's medicines policy and in relation to guidance issued by the Nursing and Midwifery Council (NMC). Nurses checked the competency of support

workers in relation to the administration of emergency medicines. These checks were also carried out annually. Medication Administration Records (MAR) were kept for each person. These were all signed appropriately with no gaps. Medication stock levels were recorded as a running total on the MAR charts and regularly checked back to actual stock levels. During our visit we observed a medicines administration round. The round was timed to match mealtimes to maximise people's compliance with taking their medicines. Sometimes people chose not to take their medicines and there was a flow chart in place with clear and appropriate actions for staff to follow if this occurred.

Medicines were stored safely in a locked cabinet and temperatures were monitored on a daily basis to ensure medicines were kept at a safe temperature. Storage arrangements met legal requirements for the storage of controlled drugs. Controlled drugs are medicines which require a higher level of security. Key information in relation to medicine administration was kept for each person. This included their photograph, how the person prefers to take their medicine, their diagnosis, any allergies and protocols for the administration of medicines which were given 'when required.' People's medicines were managed safely.

Good

Is the service effective?

Our findings

Relatives told us they were very pleased with their family member's care and support. One relative said "He likes the staff – they do understand him." Observations within the home showed that staff were delivering support according to support plans and that people looked happy and responded to staff. We saw that staff communicated effectively with people, in accordance with their individual plans, in order to provide support and care.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as infection control, food hygiene and fire safety. There was also training in relation to autism awareness and specific training around managing challenging behaviour. Staff had regular supervision meetings and annual appraisals and said they felt supported.

People were asked for consent before care and support was provided. Communication support plans made it clear how people communicated so that staff understood when people were consenting. A relative said when asked about their family member's consent "Yes, I've heard them ask for consent." Another relative described that their family member needed processing time to determine their answer and that they had heard staff explaining to them what personal care they were about to deliver and giving the person time to consider this and provide an answer. Support plans included a decision making profile. The profile described how the person liked to be given information, the best way to present choices, ways to help the person understand the information, the best time for them to make a decision and when would be a bad time for them to make a decision. Staff told us that if someone communicated 'no' they would respect this and offer the person support at a later time.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments had been completed which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as relatives to ensure that decisions were being made in a person's best interests. For example there were mental capacity assessments and best interest decisions for one person around their decision to live at The Grange and their decision to have an influenza vaccination.

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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the registered manager understood when an application should be made. Relevant applications had been submitted for people.

We spoke with staff who had a good detailed knowledge of people's needs, their preferences, likes and dislikes. Support plans were in place which recorded people's support requirements. These matched what staff told us and our observations. For example support plans gave detailed descriptions under the headings 'what's important to me' and 'how to support me well.'

In order to determine people's likes and dislikes in relation to food, a food tasting session had been held. People were served a selection of tasters which included chicken fajitas, carbonara, hot dogs and chilli. Staff observed and recorded people's reactions to the food offered. For example 'He grabbed it showing he liked it.' Based on this feedback menus were prepared by the chef. Two main choices and a dessert were offered at lunchtime and a hot meal at tea time was available. The chef made samples of the day's main choice and these were shown to people. Staff evaluated people's reactions to determine their choice. The chef also took into account people's specific dietary needs in relation to their religion and health conditions. For example, two people required a lactofree diet which they received. People using the service had very specific requirements in terms of the consistency of the food they required. For example some people required a pureed diet, some fork mashable and some needed their food cut up into bite sized chunks. The chef had records of these in the kitchen which matched with the requirements recorded in people's support plans and with the type of food we observed them to eat. Most people needed support to eat their meal and staff provided this in line with people's needs. People were supported to have enough to eat and maintain a balanced diet.

We saw that people were offered regular drinks and snacks. People had their own snack box which was kept full with snacks of their choice. People were offered drinks with every meal and in between. Staff were aware of the specific drinks which people preferred and offered these. For example one person liked to drink coffee. We saw staff offering coffee allowing the person to make specific choices about whether they would like milk or sugar.

Nurses assessed people for the risk of malnutrition using the Malnutrition Universal Screening Tool (MUST) tool. Some people, at risk, nutritionally had been prescribed supplements. This was closely monitored by nurses who checked people's weight on a monthly basis and over time. Where appropriate some people had been referred to the dietician for advice in relation to their diet. People's risks is relation to nutrition had been identified and addressed.

Health professionals were appropriately involved in people's care. People had complex conditions and needed support from a variety of health professionals. Each person had a health action plan which recorded the support required and the outcomes of any visits. There was evidence that the health action plans were reviewed monthly ensuring that people's health needs were kept up to date. Records included, for example, visits to an epilepsy clinic, visits to the dentist and reviews by community learning disability nurses. The registered manager also held monthly meeting with physiotherapy technicians where the needs of each person were discussed and assessed. Relatives of one person had recently raised concerns that they felt their relatives spine was deteriorating. X-rays were quickly arranged and the outcome discussed and documented at a 'physiotec' meeting. Further advice was to be sought from a specialist hospital. Relatives told us they were involved and kept informed about their family member's health. One relative told us that staff responded promptly to any health concerns. They said "They are quick. If he's not well, he's up the doctors fairly quickly."

Good

Is the service caring?

Our findings

Relatives and friends told us that their family members were happy living in the home. One relative said "I always feel he is well looked after. They really know him very well. They understand him better than us. He's always nicely dressed and always very happy."

Staff were supportive and caring. The registered manager in particular was observed to interact in a positive way with people, acutely aware of people's individual needs she approached them in individual ways which people clearly loved and responded to. Other staff were observed to respond individually to people, for example by cheering someone up when they were in a bad mood. One member of staff told us about a person who liked to sit on the lap of a member of staff and be hugged when they were upset. Another member of staff had developed a very good rapport with a person who demonstrated behaviour which may challenge. Due to this positive relationship a reduction in these behaviours had been noted. One member of staff demonstrated that they knew a person very well, telling us about the person's personal history, things which were important to them and activities they liked to do. These were reflected in the person's support plan and also in photographs of them taking part in these activities. The person told us that the Queen was very important to them, and there was a photograph of the person outside Buckingham Palace, displayed on the wall so that the person could be reminded of their visit every day.

People's rooms were decorated in a personalised way. One person had cushions with photographs of their family on them in their room. Due to their complex needs, they were not able to have furniture in their room, other than a bed, but the room demonstrated that the person loved football and animals and staff were also able to dim the lights. This was important as the person awoke frequently during the night. Another person who liked music and coca cola had their room decorated in line with their interests. There were photographs on the wall of the person enjoying using music decks. Others had their rooms decorated with cuddly toys, butterflies and flowers. Pictures of the person, they family and friends were evident in every room. This helped people to feel that this was their home and they were important.

People were supported to maintain close relationships with their family and friends. One person's friends told us that they found travelling to the Grange more difficult and that staff supported the person to visit them every month. One relative said "They run it like a family. They are an extension of the family. They bring him home for visits." Another relative told us "(the registered manager) makes us feel involved in his care." People were supported to make regular calls home where they were able and families were kept updated by the registered manager and people's key workers.

Relatives and friends we spoke with, were consistently positive about the care and support their family member received. One relative said "We can sleep at night knowing he is happy, healthy and cared for." Another relative told us "I think they are really good, they look after him really well. He always has nice clothes and always smells nice."

Due to their complex needs people were not able to actively participate in their support plan. The level of involvement in support plans was recorded in people's individual plans and was mostly in relation to

observing the person and their reactions. Friends and relatives confirmed they had been actively involved in developing and reviewing the person's plan of care and support. One relative said "They are always asking us about (our relative), what he enjoys and what new activities they could introduce for him."

Staff explained how they respected people's dignity by knocking on their bedroom doors before entering. Staff treated people in a dignified and respectful way and addressed them with their preferred names. People were spoken to and about with affection. Everyone was dressed respectfully with freshly laundered clothes which were matching.

People were supported to be as independent as possible. Staff described how two people who had been able to eat independently in the past, had stopped eating independently. They were encouraging them to regain this independence by supporting them hand over hand during meals.

Good

Is the service responsive?

Our findings

Relatives and friends told us they had been involved in the support plans, were kept regularly updated and were involved in regular reviews. We found that the home had worked with people through observation, preferred methods of communication and regular evaluation to ensure that support plans were tailored to people's individual preferences.

Support plans were personalised, responsive to needs, up to date and were aligned with best practice. They included a range of documents which included support plans and a health action file. Each support plan file contained personal details, a relationship map, a one page profile, an 'important to me' and 'important for me' page, a typical day, communication plan, decision making profile and decision making agreements, support guidelines and a social history. People had behaviour support plans, where they demonstrated behaviour which may challenge. These included guidance on what the person looks like when they are anxious or agitated, what they look like when their behaviour escalates, how to know when they are calming down and what actions staff needed to take to keep everybody safe.

Guidance on a 'typical day' included all support needs and wishes over a typical day and that included all personal care with a focus on maximising independence. The format of the communication plan made it clear for staff getting to know someone. The format very simply guided staff to acknowledge and respond to communication. For example 'If the person does this or says this, it means this and we should do this.'

People took part in a variety of activities and photographs of these activities were depicted throughout the home. Activities included swimming, sailing, going on a train, going to a music festival and the Goodwood festival of speed. People also took regular holidays which included taking part in a variety of activities. Relatives told us they were impressed with the activities. One relative told us "The holidays that he's been going on have been amazing, lovely photos of him on boats, mountain climbing and zip wiring." Another relative said "He likes the trains, they take him to the trains." During our inspection some people visited a local activity centre, where they took part in activities such as trampolining and music. Bowling and swimming were also popular activities which people often took part in. An outreach group visited the home in the evenings so that people could take part in evening activities such as going out to dinner or going to the cinema. Everyone had their own activities plan which was in easy read format so that people knew what they were doing and could look forward to their activities.

The registered manager was working with National Society for Epilepsy in relation to one person's epilepsy. The person's family were also closely involved. In an effort to gain insight into the person's condition some new treatments were being trialled. This was important to the person as it was a step closer to controlling their complex condition and would promote their health and wellbeing if the number of their seizures could be reduced.

The provider listened and responded to feedback about people's experiences, concerns and complaints. The complaints book included one formal written complaint which had been appropriately dealt with in a timely manner by the registered manager. One relative said "(the registered manager) listens to our

concerns be it serious or trivial, takes them on board and takes appropriate action." Another relative told us "I think recently it's been really good, feedback always taken on board and always something done." One relative told us they were sure that any concerns raised would be responded to "So far I have not had cause for concern, but if I do, they are approachable so I would raise it." Feedback forms sent to relatives included positive feedback such as '(our relative) receives care and love, we feel The Grange is an extension of our family,' '(our relative's) musical talent is supported.' Feedback was also sought through regular staff meetings and supervisions. There was a noticeboard in the home inviting staff to pin up their ideas for changes and improvements which could be made to the service. People were involved in monthly service user meetings. People were also able to demonstrate their feedback to their care through monthly meetings with their keyworker. A keyworker is a member of staff who has special responsibility for a person, ensuring they are happy in all aspects of their daily life. Staff carried out evaluations after people had taken part in activities to determine whether they were enjoying the activity or whether they would like to try something new.

Good

Is the service well-led?

Our findings

There was an open and transparent culture within the home. Staff were able to raise any issues or concerns with the manager who, they told us, always listened and responded. Relatives told us they had a good relationship with the registered manager whom they respected. The area manager had recently held a workshop in the home about promoting work place culture. As a result a dignity champion had been appointed to drive forward the approach of compassionate person centred care.

Relatives were very positive about the registered manager and her leadership of the home. One relative said "We can't thank (the registered manager) enough, she has made the transition easy." Relatives were also pleased that they had been invited to a recent staff meeting to discuss their relative's care. They felt involved in their relatives care within the home and were grateful to share their knowledge of the complexities of their relative's care built up over time. Another relative told us "I feel (the registered manager) is an excellent manager. She seems to have her finger on the pulse."

Staff told us they were aware of their roles and responsibilities, as these had been discussed in a recent team meeting. Following the recent staff restructuring the registered manager had prepared a presentation for staff so they understood the new roles which had been created, their own role and how their own role linked with other staff members. A SWOT (strengths, weaknesses, opportunities and threats) had been carried out to involve staff in determining a way forward. From this an action plan had been developed demonstrating how improvements to the service were planned. For example training needs were identified and recorded.

The provider held meetings for registered managers in the local area; this helped the registered manager to view the home more strategically and in the context of local themes and activities. For example at the last meeting registered managers were advised on themes around incident reporting and training. There was also networking amongst local registered managers.

The registered manager told us that people regularly accessed the local community. One person took regular walks in the local area and was well known by local residents. They also liked to attend the local church. People also attended special viewings of films at a local cinema and went bowling. The use of public transport was limited due to people's complex needs.

The registered manager submitted relevant notifications to the Care Quality Commission (CQC) in a timely way. A notification is an important event which the provider is required to tell us about. The registered manager was aware of the provider's vision and values, which included, passion for care and positive energy. She felt these values were reflected through the passion of her staff to make a positive difference in people's lives. Staff felt involved in contributing to the development of the service and this was reflected in the care delivered and the family feeling within the home. The registered manager's vision for the future was to develop the home as an epilepsy specialist service. This involved building on existing links with the National Society for Epilepsy and working with the Havant learning disability team who were already providing advice for support plans around specific epilepsy needs. She was also reviewing specific epilepsy

equipment for use in the home, such as epilepsy sensor mats.

Checks were undertaken to ensure the quality of the service. A health and safety monitoring tool ensured that window restrictors were checked weekly. Other checks carried out included hot water temperature, fire system, weekly inspection of bath chairs and wheelchair checks weekly.

Checks in relation to the overall running of the home had been undertaken such as a fire safety audit and a legionella risk assessment had been carried out by an independent company to ensure the risk of legionella remained low. A quarterly audit was carried out by the operations manager and was based around the five questions asked by CQC during inspection. An annual audit was undertaken by the provider's in house audit team. Any actions derived from these two audits were added to the consolidated action plan. We tracked actions from the provider audits through to the consolidated action plan and confirmed they had been completed.