The David Lewis Centre

Pathways and Community - Warford

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection was unannounced and took place on 11 February and 18 March. This location was last inspected in February 2014 when it was found to be compliant with all the regulations which apply to a service of this type.

The Pathways and Community – Warford service supports adults with complex needs to attain quality of life and to maximise their potential in a safe residential environment. Pathways and Community – Warford provides care for adults of all ages and some people who use the service spend their whole adult life with the service. The service draws on the rest of the David Lewis Centre for certain support arrangements most notably clinical, social work and administrative services as well as other central facilities such as kitchens.

The service is located on the site of the David Lewis Centre which provides a range of assessment, treatment and care for people with severe epilepsy and associated conditions such as autism and learning and physical disabilities. Pathways and Community – Warford uses a number of separate buildings on the main site as well as

Summary of findings

some houses close by. There are 126 places spread out between 16 separate units. Units vary in size from a single person to the two largest which have places for 21 people in each.

There is a registered manager at Pathways and Community – Warford. 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.

We found that the care provided took account of individual preferences and needs whilst providing high levels of clinical and other support. We found that staff were professional and that there was a relaxed approach with people who used the service who were generally at ease

People who used the service had access to a range of activities on a daily basis. There were good arrangements for people to eat and drink. Staff were well trained and the provider checked to make sure that they were suitable to work in the service. The service was managed proactively and could draw on the resources of the wider David Lewis Centre.

We found that unexpected staff shortages could occasionally compromise the level of care when there was a lower staff ratio which in turn might curtail the range of activities available to a person. Medicines were administered safely.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service told us they felt safe and there were clear arrangements in place for staff to report any concerns they might have in this respect. There was good access to clinical support if required and a clear and thoughtful approach to responding to behaviour that was unexpected or unusual.

The provider checked to make sure that staff who worked in the service were suitable. Medicines were administered safely.

Is the service effective?

Good

The service was effective. There were good arrangements for people to eat and drink with food provided from a variety of sources so as to promote choice. People could express choice about what they wanted to eat and healthy option dishes were available.

Staff were well-trained and the provider had systems for tracking this so as to maintain it. The provider had robust arrangements for making assessments and best interest decisions under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. Staff had a good knowledge of the people they were caring for. This meant that they were able to establish positive relationships with people who used the service. This was reflected in the ease and wellbeing we felt with people who used the service.

Staff were professional in the way they conducted themselves and did their jobs and respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. Staff went out of their way sometimes to meet people's individual needs and involved them and their families in care planning when they could.

Care records were individualised so that preferences could be reflected and appropriate forms of communication (such as graphics) used where appropriate. People could undertake a wide range of activities both in the community as well as on the site itself.

Is the service well-led?

Good

The service was well-led. There were good systems of audit throughout the service with communication between all levels. Staff working at the front line could feed issues back to senior management for attention and these were acted on.

The provider had strong forward planning systems including career pathways for its staff. The provider learned from events within the service so as to inform future practice.

Pathways and Community - Warford

Detailed findings

Background to this inspection

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

The inspection was unannounced on the first day and took place on 11 and 12 February and 18 March. This location was last inspected in February 2014 when it was found to be compliant with all the regulations which apply to a service of this type.

The inspection was undertaken by two adult social care inspectors together with a specialist adviser with expertise in nursing and the needs of people with epilepsy and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service in this case services for people whose behaviour can be unusual or unexpected. A pharmacy inspector visited on 12 February and a single adult social care inspector returned to complete the inspection on 18 March.

Before the inspection we asked the local authority safeguarding and commissioning teams and the local branch of Healthwatch for any information they held about the service. We considered this together with any information held by the Care Quality Commission (CQC) such as notifications of important incidents or changes to registration.

During the inspection we talked with eight people who used the service. People were not always able to communicate verbally with us but expressed themselves in other ways such as by gesture or expression. We spoke with five of their relatives. We talked with 11 staff as well as the registered manager and the chief executive officer of the David Lewis Centre.

We looked at records including eight care files and three staff files. We looked around the buildings used by the service as well as the wider David Lewis Centre site and visited six of the units in which people who used the service lived. We also visited the central kitchens, medical centre and human resources and training department.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe both with the staff and in the environment provided by the service.

We saw that some people lived in the service for a large part of their lives and aged there. We spoke to an older person who used the service who remained as independent as possible but had become prone to falling. They told us that they still felt safe because they knew that help was available if they needed it. Staff told us that in recognition of this person's increased needs they had been allocated one-to-one support around mobility to make sure they could achieve this safely. Mobility equipment and physiotherapy had been made available to further support this.

We saw that this person chose to spend a lot of time alone in their own room. We were told that staff remained near the room and checked that this person was safe from time to time. We also saw that this person had access to the call system which can summon the on-site emergency response team if required.

People who used the service may have severe forms of epilepsy and other life-challenging conditions which require an urgent medical or nursing response. There was an internal aid call system for staff available 24 hours a day for emergencies and when activated designated staff within and outside the unit would respond. During the inspection an alarm was activated and inspectors witnessed the system in use. The alarm was a false alarm but nevertheless all staff responded as expected.

We looked at care records and saw that they contained relevant documentation including comprehensive risk assessments and detailed person centred care plans that reflected the assessed need relating to the person's condition. This meant that the service was able to provide care which took account of and where possible minimised risks to the person concerned.

We saw that the records contained detailed information relating to the management of the person's medical condition such as an epilepsy risk management record with a review of seizures and medication plan. Where appropriate the in-house speech and language team were involved and the relevant choking risk assessments were undertaken. We saw records that indicated that people were weighed on a monthly basis so that any variations could be explained. We found that the service utilised body maps to record injuries and falls assessments were kept for those people at risk. Detailed mobility moving and handling assessments were undertaken with clear instructions on the use of any aids contained within the records.

The registered manager told us that each unit either had its own residential manager or might share a manager with another house together with a team leader, one of whom was on duty at all times as well as care officers. There were also two night supervisors who worked opposite each other so that there was always one on duty at all times. There was also a duty manager on call.

Staff told us that they thought there were enough staff. We saw that most houses operated on a staffing level of one to one for people who lived there with additional support from the senior staff. This was different in the larger houses for the older residents where staffing was lower but staff still confirmed that they felt that staffing levels were appropriate.

When we visited one unit on the second day of our inspection we saw that staffing had been reduced because of staff absence. This meant that supervisory staff were having to cover until another member of staff came on duty in advance of their scheduled shift. We were told that planned staff absence could be covered from the whole staff pool working at the David Lewis Centre but that unplanned and short notice absence such as sickness could present the difficulties we saw. Staff told us that they felt there was a lack of bank staff to cover this eventuality and "When we're short staffed we do twice the job for the same money". The registered provider told us that there were in fact 41 members of bank staff available across 316 care officer positions which meant that there was 13% cover.

Staff were clear that staffing levels were always safe. They told us "The staffing ratio is always safe. Sometimes (when there is a staff shortage) you have to work with more than one person and this can have an effect on their behaviour. Sometimes you have to swap around to see what other activities you can do". We discussed this with the registered manager who was aware of the situation.

Each unit also drew from a central core of clinical and other services provided by the unit known as Assessment and Treatment, Warford. In particular care staff could call on the

Good

Is the service safe?

team of centre cover nurses who would respond to the call bell system when it was pressed. The centre cover nurses were available throughout the day and night each day and would respond to any medical emergency (e.g. cardiac arrest) or where a member of care staff felt they needed additional support.

We asked staff about safeguarding. One member of staff on an all-male unit told us "Our job is to keep our guys safe and make sure they are not abused". The staff we spoke with identified safeguarding as a high priority and expressed no concerns about the safety of people who lived in the service. One told us they followed the principle "If you're not sure, report it" and another said "I think people are well-looked after and safeguarded. I would know if something was wrong because I know (the people who used the service)". Staff told us that they were each provided with a card which they could carry advising them of safeguarding procedures.

We asked staff if they could recall any recent incidents which had given rise to safeguarding concerns. One told us about a specific incident which had been dealt with through increased staff supervision. Staff told us that they had received training in safeguarding as part of their induction and we saw from the current annual training plan that safeguarding training also formed part of the annual refresher training programme for supervisory, care, administrative and support staff. There was a dedicated telephone line reserved for reporting safeguarding matters (including out of hours) which were dealt with by the social work department. Staff could contact this service direct and independently of their management if they felt they needed to.

We were told that as well as being subject to seizures sometimes people who lived in the service might behave in an unexpected way that might present a risk to themselves or to those around them. Staff explained to us that they sought to implement positive behaviour management utilising redirection and prompting if people became challenging. We saw that the service had a specialist challenging behaviours nurse who developed comprehensive care plans that were reviewed on at least an annual basis or at any point the person's behaviour changed significantly.

We checked to see if the provider took precautions to make sure that the staff who worked in the centre were suitable to do so. We looked at staff files and saw that they included application forms from which the provider could check an applicant's employment history, references which had been checked with person who supplied it, and records of interview. The provider obtained its own checks from the Disclosure and Barring Service (DBS). These checks help an employer to verify any criminal record and to take this into account when considering employment. We saw that nursing registration was checked on a monthly basis and that these checks were up to date.

We saw that medicines, including oxygen, were stored safely in all the units visited. Medicines were kept at the right temperatures.. The use of medicines was audited on a regular basis, and any concerns identified were acted upon. Accurate records were kept for medicines ordered and received.

We looked at the medicine records for 26 people across four houses and found no omissions in them. Special instructions were written on medicine charts for emergency medicines and for regular medicines if appropriate (for example, "take at least 30 minutes before food, drink or other medicines"). All medicine entries on charts were signed by a doctor or nurse. Nurses who were not prescribers were authorised to supply some medicines (including antibiotics) to people by a written patient group direction (PGD).

Controlled drugs were prescribed, stored and recorded in the way required by law. Staff who administered medicines were appropriately trained and competent. We saw some people being given their medicines at lunchtime: The member of staff administered medicines in a safe and friendly way.

Good

Is the service effective?

Our findings

One relative told us "It's great that there is medical help there on site". We spoke to other relatives who emphasised that they felt more confident that their relative's health needs were being met due to the on-site medical resources and the good links with external resources.

During the inspection we had the opportunity to visit the on-site medical centre and interview one of the matron nurses. The centre provides GP surgeries for people and each of the six nurses in post act as practice nurses. They were allocated a number of residences across the campus to liaise with and provide health care treatment and advice where appropriate.

The staff providing direct care on each of the residential units were not medically qualified. The matron nurse we spoke with was confident that these care staff were equipped to manage people who regularly had epileptic seizures. They told us "You are able to build up a relationship with staff and residents across the units you liaise with". The matrons responded 24 hours a day to any emergency calls.

When first employed by the provider staff were required to undertake a 17 day induction programme which was made up of a mixture of online and face to face methods. Following induction new staff had to complete a six month probation period during which their performance had to be satisfactory. Subsequently staff undertook refresher training to keep their knowledge and skills up to date. Staff and relatives commented positively on the value of the training. One relative said "The staff are well-trained – it's continuous".

We found that where required people had a care plan relating to nutrition and fluid balance monitoring. We were provided with very detailed plans which told staff whether people were able to eat independently, required any equipment to help them or needed special arrangements for dysphagia (difficulty with swallowing). The plans also described the measures required and whether the person might need help afterwards such as with washing their hands and face.

We saw during one lunch time that people had access to drinks and food and were provided with appropriate staff support. We saw that people made choices regarding main meals from the central kitchen and separate food and drink was available to them from their own house kitchens. Menus were agreed during meetings on each unit with the people who lived there. People then chose their food each day from a daily menu.

We visited the central kitchen which supplied the food to each unit. We talked to the cook who was on duty and they showed us the menus which were balanced and varied. The menus offered people a choice of dishes with specific "good for you" dishes highlighted.

People who used the service had access to a specialist speech and language therapist who advised on swallowing difficulties. We asked to see how food was presented for people whose dysphagia meant that it required pureeing. We saw that this was purchased in ready prepared form. Once pureed each separate ingredient had been reformed by the manufacturer so as to resemble the original foodstuff in shape and colour. This meant that the dish could be presented attractively and that people would be able to associate the different foods with their original shape, colour and smell.

Staff in one house explained that they were keen to provide non-processed foods for healthy eating. In this house a designated member of staff had taken the lead on food, diet and meals. Because some of the people who used the service could not easily communicate the staff used a rating system to monitor what people ate or drank to determine if they were eating correctly or disliked something. We saw that staff also trialled many different foods and made this into an event and activity for people to engage with. They made a photographic record of the different foods and of the whole event.

Some units operated a mixed system whereby some meals (usually on weekdays) were provided from the central kitchen but on other days meals were prepared using food and drinks delivered by a local supermarket. Each unit was free to make this arrangement for themselves thus offering the people who used the service greater choice. In some units people were able to go shopping for themselves with staff assistance. One person told us though that whilst they knew they were "picky" about their food they felt they were not able to go out shopping enough so as to have the food to meet their preferences. We saw that there was also a Rainbow Café next to the kitchens where people could purchase food and drinks. This together with the site shop assisted with the development and maintenance of life and social skills.

Good

Is the service effective?

Staff told us that they realised that someone might not eat if they were uncomfortable in their surroundings and so we saw that people were given the option of where they preferred to have meals. As meal times could be noisy the nutrition plans included a note about whether people were noise tolerant or not so that this could be taken into account.

Staff told us that they felt equipped to carry out their role and had access to training relevant to the work and held National Vocational Qualifications (NVQ) in health and social care at various levels. NVQ (and their replacement the Qualifications and Credit Framework) qualifications are competence-based which means that people learn practical, work related tasks designed to help them develop the skills and knowledge to do their job effectively. We looked at training records which showed that training completion levels of better than 95% were being achieved. This meant that staff were trained to do their job and their training was being kept up to date.

We asked staff how they approached the need for people to consent to the care they were provided with. They told us that if a person refused care that was important then they would try to reason with the person by explaining the care and the consequences of refusing it. One member of staff said “But at the end of the day, if they refuse then that is it (the end of the matter)”. Both said they would report the refusal so that it could be recorded. The Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS) makes provision for people who may not be able to make some decisions or give consent for themselves. Pathways and Community – Warford is a care home for these purposes and must observe the requirements of this legislation.

We saw that the provider was following the requirements in the DoLS. We saw that they had submitted 127 applications to the relevant supervisory bodies and maintained systematic records so as to keep track of them once they were authorised (64 at the time of the inspection). We looked at the paperwork for a sample of these and found them to be in order. We saw that there was evidence in the records of mental capacity assessments being undertaken and reviewed by the provider. We saw that mental capacity assessments were undertaken by nursing staff and best interest meetings were held where required. We checked a number of records of these best interests meetings. We saw that in each instance they considered the best interest in relation to a specific issue such as the need for an operation, special diet, or other consideration.

We saw from the annual training plan that training in mental capacity and DoLS was included in induction training for all care staff and was set to be refreshed at two yearly intervals. The provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act and the specific requirements of the DoLS. In each house there were DoLS guides, safeguarding team access details and other safety and procedure protocols visibly displayed in staff areas.

People had access to the full range of in-house health care services provided by the David Lewis Centre through the Assessment and Treatment – Warford unit. This provided them with most of the clinical services they required such as doctors, nurses, psychologists, occupational and speech and language therapists, physiotherapists, podiatrist, dentist and the dietician. The unit also arranged for external services such as GPs to attend where necessary.

We looked around several of the buildings in which the people who used the service lived. We saw that the standard of maintenance and decoration of these buildings was to a high standard and that the environment was clean.

Good

Is the service caring?

Our findings

All the relatives we spoke with told us that they were kept involved and up to date about their family members. They told us they thought that staff were knowledgeable, proactive and described them as "very good". All relatives felt that they had the opportunity to provide input into care plans and were always welcomed when they visited the service. They told us "Staff are wonderful - they keep us completely involved and up to date. I have no worries about just popping in" and "Even though I live two hours away I feel confident in (my relative's) support. The staff always communicate with me".

One relative told us that staff had come into work early and otherwise tailored their working hours around one person's individual needs in order to support them with preparing for a surgical operation. They told us "Staff have been really flexible coming in at different times to their normal hours to make sure (my relative) is having the best preparation for the operation".

When we visited the residential units we saw that each person had their own bedroom which was individually decorated and furnished to their tastes and preferences. These often reflected their hobbies and interests such as sports or music. Staff worked with people so that they could identify these preferences and choices so that they could then choose the things they wanted and how they wanted their personal environment to look. Staff told us they felt that it was important that people made their own space individual as it gave them ownership of it and made it something they could be proud of.

Staff showed a good understanding and knowledge of the people they were supporting. They were able to provide a great deal of detailed individual and personal information about the people who used the service. Staff could explain how they communicated with and understood people who had difficulty communicating verbally or whose mental capacity might mean they could not make certain decisions easily. Staff used planning tools such as person centred planning, care planning and communication plans to learn about and make a note of each person's preferences.

In each house we visited staff introduced us to people who used the service. We saw that staff had a good relationship with people who used the service. We saw them approaching staff members and it was apparent that they felt at ease in doing so. Throughout the inspection we saw staff acting in a professional and friendly manner with people and treating them with dignity and respect.

During our visit to one unit we saw that people often had at least one to one care staff involvement and we saw people being encouraged to participate in planned or impromptu activities such as reflective time in the sensory room or in physical or art and craft activities. One relative told us "The staff work very well – they are unobtrusive" and "The staff are always polite but I can have a laugh with them". One member of staff said "(The policy on privacy is) very strict. Knocking on doors, making sure that doors are closed when they need to be" and another told us they followed the principle "I treat people as I'd like to be treated".

The service is located on a large site with a number of different facilities available on it. During our inspection we spent time visiting these facilities and walking throughout the site. During these walks we met many groups of people who used the service some of whom were with staff and others who were in small groups. We were struck by the friendliness and courtesy of all the people we saw during our inspection. Whilst everyone was purposefully on their way to a specific activity most people seemed calm and relaxed and met us with a smile or a wave and a "Hello" or "Good morning" as we passed.

Staff showed us how they had implemented changes to create a better environment or quality to daily life for people. One team leader told us that they had requested an overhaul of the facilities and environment to better reflect the way that people's needs had changed. They explained how people who used the service had been involved in this to ensure the changes were as they would want them. The staff told us that whilst they knew they needed a plain, clean environment they also wanted it to be more homely and personal for people who lived there. They told us "Who has just plain beige in their homes? I wanted the place to be decorated in a way the residents wanted". Whilst we were visiting this unit people showed us their newly refurbished rooms and explained how they were assisted to make choices over the decor and furniture.

The resident group on the unit were sometimes too disabled themselves to easily contribute to their care planning, however we found evidence of family involvement in helping to develop and shape appropriate care plans. We saw the minutes of a residents' council

Good

Is the service caring?

where people who used the service and their supporters were able to express their views about the service and noted that this meeting had been attended by both the chief executive officer and the registered manager.

The provider had made arrangements to implement a recognised care pathway for people who were nearing the end of their life. The aim of this pathway was to ensure all people received high quality end of life care provided that encompassed the philosophy of palliative care. We saw that training in this pathway was included in the provider's training plan.

Good

Is the service responsive?

Our findings

One relative described the difficulties that they had had whilst living with a person before they were admitted to the service. They told us that they felt these difficulties had improved now that this person had come to live in the service. They told us "(My relative) has the support that helps them manage their behaviours and meets their needs as they are personal to them. The environment works as they can take themself off too and have time to be alone".

Another relative told us how the service catered for one person's needs in a way that wasn't available to them anywhere else. They told us that the care this person had received had in turn impacted positively on this relative's life. They told us ""The support (my relative) gets now has made a massive difference as we couldn't provide them with the same life as they get now at David Lewis (i.e. Pathways and Community – Warford)". It is much better as at home there was nothing suitable for them". They told us that the service involved the person in their own care planning. They told us "The team (at the service) talk to (my relative) and find out what works for them and what they want to do. They help them to manage their behaviours and needs as its all personal to them" and ""Everything is individual to (my relative) so everything is about them".

We saw that risk was balanced with the need for people to express choices and preferences. For example whilst the physical environment was homely it was also organised, decorated and furnished to ensure the safety of residents and staff. We saw that specialist equipment was available. We discussed with people and staff the different preferences they had for the use of hoists and equipment and how this might vary depending on personal choice of person and situation.

The houses were clean in both communal and in people's personal areas such as their bathrooms and bedrooms. We saw that each unit was quite self-contained including medicines storage areas and laundry facilities. Staff explained that people's washing was done separately to ensure that they received only their own clothes but also as a means of infection control. We were told that a dedicated member of staff was about to be appointed to manage infection control.

We saw that the service used a paper based record and care planning system with records held in ring binder folders and neatly stored in a cupboard in the unit office. Because the cupboard was lockable people could be reassured that their personal information was kept confidential. We saw that senior staff maintained the records and updated the care plans on a monthly basis, with all other care staff using the daily report records within the notes to document a contemporaneous record of care. We saw that one unit was trialling a new online system of care recording which appeared to offer opportunities for this to be updated in real time and the information to be more readily available to care staff.

We checked four sets of records in detail from pre-admission to present day and overall we found them to be stored correctly, neatly and tidily with contents sections clearly indexed and methodically arranged. The records included a "one page profile" of the person which illustrated a number of key elements such as likes and dislikes, hobbies and "things you need to know about me" plus communication strategies, danger awareness and "things important to me" elements.

The use of pictorial records helps people who have communication difficulties to take part in and be involved in their own care plans. The use of person-centred tools such as a "one page profile" means that the service can be organised around the needs of the person rather than the requirements of the service. As well as encouraging and facilitating involvement this would help any new member of staff to learn a great deal about the person in a short period of time. All care records contained a recent photograph of the person so that any unfamiliar staff could recognise them. All the records we checked contained relevant assessments including comprehensive risk assessments and detailed person centred care plans that reflected the assessed need relating to the person's requirements.

We found evidence of systematic reviews and evaluation of care plans and overall care with evidence of full multidisciplinary team reviews including the designated unit medical doctor, specialist challenging behaviour nurse with the involvement of other health and social care professionals such as social worker and physiotherapist. People's care plans were reviewed by the multidisciplinary team on an eight week basis and by the residential manager for the service every four weeks.

Good

Is the service responsive?

Staff told us that even whilst care plans had set review dates they made updates as and when they learned something new or something changed. Staff told us that they ensured that they communicated with each other about the people they were supporting so that everyone was clear and up to date with a person's needs and aspirations.

We saw that people had the opportunity to provide feedback and voice their ideas at residents' meetings and also at any time to staff and management. We saw minutes of these meetings. One person told us about how the grass was being cut too early and this was disturbing their sleep. This was fed back to the chief executive officer who then arranged that the grass would no longer be cut at times that would disturb people. Residents also made decisions on things like names for their facilities so that the onsite social club was renamed at their wish and also logo designs for the service were influenced by them.

Staff also assessed and then made requests for specialist equipment and described how they used assistive technology to meet people's needs. One person showed us an array of mobility equipment in their room that they had been provided to give them choice over how they moved around the house depending on how they felt each day. As their mobility had deteriorated they had not only been given a wheelchair but also standing equipment so that they could choose depending on the situation.

We found clear evidence of case record audits undertaken by the unit residential manager in the files and evidence of a confidentiality record with the use of an access to records recording sheet to identify who had looked at the records including a date and reason for access.

We asked about how people who used the service spent their leisure time. Staff showed us a file with pictures documenting their themed mealtimes, activities and their outings. Staff explained how they worked with people to plan and prepare them to be able to access different opportunities that provided sensory and other opportunities for the people they supported. The staff explained that they planned holidays and also conducted fundraising involving the people who used the service as part of the process. Staff explained how they assessed people's reactions as feedback to the ideas they suggested so that residents made the choices.

We saw that the service was responsive to the needs of the people who used it. We saw staff providing care, responding to people's needs in an appropriate way and engaging people in planned or spontaneous activities. Each person had a planned programme of activity with evidence in the records that this had been carried out. Some of the activities we saw recorded as having been completed included taking the bus to the local sports centre and using local off-site facilities such as the leisure centre and library, attending college and going shopping. On site activities included listening to music and watching DVDs and films, using the sensory room, and arts and crafts. The spacious site at the David Lewis Centre afforded opportunities for walking and during our inspection we saw that people were able to use adapted bicycles to cycle around. However four people told us that they would like to do more with their time. One relative told us "The care is ideal. (My relative) is in a walking group. He also has a job and he gets paid for it".

We saw that there were a number of other facilities on-site that people could make use of such as social activities clubs and swimming pool and gymnasium and education facilities. The unit had use of a mini-bus which was regularly booked out for individual or group trips for people who used the service. We also visited a house on the edge of the site. People could move into this house with others when they were ready for more independence from the main site and could learn to undertake more self-care skills. We saw that one person had taken the step of trying a move to even more independent accommodation in a nearby town. This showed that the provider encouraged structured transition between this service and those offering greater levels of independence.

Pathways and Community – Warford maintained a log of complaints in each of the individual units and we saw that these were monitored as part of the visits made by members of the executive committee. These checks made sure that complaints had been responded to promptly and that alternative formats were available if required. The registered manager told us that he was about to introduce a further audit process for complaints. We looked at two complaints and saw that they had been dealt with promptly and appropriately. A relative told us that they had made a complaint in the past and that notice had been taken of this.

Good

Is the service well-led?

Our findings

There is a registered manager at this location. Staff reported that their manager was approachable. One relative told us that they thought the standard of care was "All down to the people at the top. The chief executive here is excellent".

Pathways and Community – Warford is part of the David Lewis Centre which is a registered charity with a board of trustees. We saw that members of this board made regular site visits to all parts of the centre including this location. We saw the latest reports each of which had been made by a different trustee. Matters which were reported upon included a discussion of ways to improve clinical arrangements as well as a review of any recent deaths and other significant medical events and visits to some of the facilities on the site. It was clear from the reports that we saw that that during their visits the trustees took their responsibilities very seriously and engaged with both the staff and the people who used the service. This meant that the board received regular information about the running of the service which was independent of the management or staff. No matters of serious concern had been identified in any of these reports.

There was also an executive committee which included the chief executive officer (CEO) of the Centre together with the Directors of Finance and Human Relations. We saw that members of the Executive Board completed monitoring visits and wrote a report after each one. We looked at two examples of these monthly reports and found that they were comprehensive, detailed and clear on any requirements for corrective action. All these reports were also sent to the board of trustees. We were given a structure chart which included photographs of these officers so that people who used the service could identify them.

We saw that the provider also undertook internal inspections and were provided with a document showing that these had taken place between over the last year. We saw that these were completed quarterly and were carried out by the residential manager. The reports were then sent to the registered manager and seen by the CEO and any matters raised with the appropriate manager. In addition the registered manager had given all his residential managers audits to complete in relation to night staff, complaints and kitchens (cleaning schedules).

The registered manager told us that he felt well supported by colleagues including other directors and the CEO who conducts his supervision each month. He told us that he felt supported by the trustees who have a good knowledge of care practices and whom he described as "very approachable".

There was a variety of ways in which communication was maintained throughout the service. We were told that a team briefing was sent out every month and were given a copy of the latest edition. The briefing included general information such as about new appointments to the staff, employee opinion survey follow up, budget and finance, Care Quality Commission (CQC) developments, projects, and brief reports for each service and a plan of a new build project. We were told that all staff had access to the team brief.

The residential manager held regular meetings with his supervisors and we were provided with a copy of the minutes of meetings which had been held a few days before our inspection. We also saw minutes of the staff consultative forum. It was clear that care and attention was paid to communication in the service

We that a supervision policy dated October 2014 had been issued by the human resources department. We looked at a selection of supervision records and found that these were satisfactory. Staff we spoke with confirmed they had access to formal supervision and an annual appraisal and said that they felt supported by senior staff within the organisation. Staff also explained that they have good opportunities to learn from each other and from the standard methods of appraisals and development. They identified monthly supervision and staff meetings, good training and the use of staff surveys and feedback forms as contributing to this.

Staff told us that they found the management accessible. We saw that there were arrangements for the CEO to make quarterly visits to the units. One supervisor told us that they had realised that the people who used the service had changing needs and devised a dependency tool so as to measure this. They told us that after submitting this to the CEO the staffing on their unit had been increased.

The provider gave us a copy of the detailed employee development strategy for the current year. This included an employee opinion survey in which positive feedback was recorded in almost every area. Action was recorded against

Good

Is the service well-led?

specific items for example staff had asked if their training could count towards national recognition and the provider had arranged for accreditation by an internationally recognised centre. The provider had resisted staff requests to reduce the length of annual refresher training because it felt it was necessary to "maintain high standards of safety and provision of care".

The provider had devised a clear career path for carers which they could follow through different levels of seniority and had audited its training arrangements to confirm that they would incorporate all the standards for the forthcoming care certificate which is about to be introduced. The care certificate sets out explicitly the learning outcomes, competences and standards of care that will be expected in the health and social care sectors and will be replace both the common induction standards and the national minimum training standards.

When we discussed staffing levels with the registered manager he showed us a tool which monitored staffing and skills requirements against staff available for each individual unit for the last month. This showed that the registered manager was monitoring the staffing situation and could identify areas in which there was requirement to increase or otherwise adjust staffing. The information on this tool suggested that the staff group at the service was stable and supported his view that it was unexpected sickness absence that put the most pressure on staffing resources. We saw that there were clear job descriptions for the different roles employed within the service and these had been rewritten to follow the CQC domains used in this report.

We saw that the provider monitored trends and developments in care and used this information to determine areas for special study or development. For example we saw that at the time of our inspection the provider was monitoring and analysing events surrounding sudden deaths, an understanding of which is particularly important when providing services with people who may experience severe seizures.