# The Regard Partnership Limited

# Two Wells

## Inspection report

Two Wells
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 12 March 2016 and was unannounced. The inspection continued on 13 March and was announced.

The service is registered to provide personal care with accommodation for up to four people with learning disabilities. A person proudly showed us around their home. The service had an open plan living and dining room with a conservatory which led into an enclosed rear patio and garden area. There was one en-suite bedroom on the ground floor and a staff sleep-in room come office opposite the kitchen. There were a further three bedrooms on the first floor and a shared bathroom.

The service has a registered manager in place. 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.

The service was safe because innovative and creative systems were in place for people to identify risks and feedback to staff what support they needed. People used visual templates to convey and communicate their support needs.

There were emergency evacuation plans in place for each person. These plans detailed how people should be supported in the event of a fire. There was a standard evacuation plan placed by the front door and a pictorial version for each of the people.

There were sufficient staff in place to provide the care and support people required. Employment checks were carried out so that appropriate staff were recruited who had the skills and knowledge required to fulfil the role. Staff were able to tell us how they would recognise signs of abuse and who they would report concerns to.

Medicines were stored and recorded appropriately. Regular audits were carried out and people were supported appropriately to manage their own medicines safely.

Staff were knowledgeable of people's needs and received regular training which related to their roles and responsibilities. The organisation provided all new staff with a staff handbook during their induction period. This covered key topics such as attendance, benefits, policy summaries and code of practice. Staff received regular supervision and appraisals.

Staff had a good understanding of the principles of the Mental Capacity Act 2005 and demonstrated positive person centred approaches around obtaining consent from people. People's capacity was assessed and best interest decisions recorded when appropriate.

People were supported using creative, accessible person centred tools to plan menus, learn about healthy eating, cooking and food shopping.  A person told us, "I like food here; I cook tonight, fish and chips. I like chicken casserole. I take part in menu planning meetings and food shopping".

People were supported to maintain good health through regular healthcare appointments. Records we reviewed showed that people had attended annual health checks including visits to their GP. and dentists. A health care professional told us, "Staff attend health checks with people and use approaches that promoted their independence".

People were supported by staff who understood personalised care and practice. Staff were kind, empathic and had developed positive relationships with them which aided them to understand people's individual needs.

The service was responsive to people's changing needs and worked closely with people to review these to ensure they were at the heart of what support they received. People set their own goals and were supported to achieve these. The registered manager told us on several occasions that it was all about the people.

Complaints, concerns and suggestions were used in a positive way to review and develop the service. These were well managed and seen as a means of understanding how to improve people's experiences.

The registered manager promoted an open, transparent culture within the service which was person centred and empowering for both people and staff alike.

People, staff, relatives and health professionals told us that the registered manager was good. A staff member told us, "The registered manager shows respect to staff and people. She talks to people and staff. She listens to us and is open to suggestions and supportive of new ideas".

Quality monitoring systems were in place and actions recorded and followed through. Systems in place included management check, audits and observations.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe. People were innovatively empowered to identify and assess their own risks and say how they wanted staff to support them to minimise these.

Creative approaches and visual check lists had been created which enabled people to complete health and safety checks which raised their understanding of risks, hazards and how to stay safe.

Staff were able to tell us how they would recognise signs of abuse and who to report it too. Information was readily available to people and adapted to their preferred method of communication.

There were sufficient staff to meet people's assessed care and support needs. Staff had appropriate pre-employment checks carried out.

Medicines were managed and recorded safely. Medicines were only administered by trained staff.

People were regularly assessed and were appropriately enabled to manage their own medicines safely.

### Is the service effective?

Good

The service was effective. Staff received regular training which included role specific training based on the people's needs they were supporting.

Staff received regular supervision and appraisals.

Staff had a good understanding of the principles of the Mental Capacity Act 2005. Capacity was assessed and best interest decisions were recorded when necessary.

People were supported to take part in menu planning meetings and to cook and go food shopping.

People used healthcare services as and when they needed them.

## Is the service caring?

Good

The service was caring. People were supported by staff that knew them well and used creative, innovative person centred approaches to deliver the care and support they required.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected their privacy and dignity.

## Is the service responsive?

Good

The service was responsive. People were supported by staff that recognised and responded to their changing needs whilst ensuring that they were involved in their own reviews.

People were supported and encouraged to be involved in a variety of different activities at the service, in the community and at day service.

People's feedback was used to make improvements to the service which benefit the people who live there.

## Is the service well-led?

Good

The service was well led. The registered manager promoted and encouraged an open working environment.

The registered manager spent time talking and listening to people.

There was strong leadership and staff felt supported and listened to.

Regular quality audits and checks were carried out to make sure the service was safe and that staff had the skills they needed to do their job

# Two Wells

**Detailed findings**

## Background to this inspection

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

This inspection took place on 12 March 2016 and was unannounced. The inspection continued on 13 March and was announced. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service. We spoke with the local authority contract monitoring team to get information on their experience of the service. We also looked at the previous inspection report.

Before the inspection we did not request 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 what improvements they plan to make. We gathered this information from the provider during the inspection.

We spoke with three people who use the service and two relatives. Two health care professionals who both had experience of the service provided feedback by telephone following the inspection.

We spoke with the registered manager, and three staff. We reviewed two people's care files, policies, risk assessments, quality audits and the 2014/2015 quality questionnaire report. We looked at health and safety records, medication and activity plans. We observed staff interactions with people. We looked at two staff files, the recruitment process, staff and people's meeting notes, training, supervision and appraisal records.

Good

# Is the service safe?

## Our findings

People told us they felt safe in their home. One person said, "I like this house, I'm happy here and feel safe. I like the staff". Another person told us, "I feel safe here with people around me". A further person commented , "I'm safe here, staff look after me but I'm free to do what I want to".

There was an open and transparent culture embedded in the home. The service used imaginative and innovative ways to manage risk and keep people safe, whilst making sure that they live a full and meaningful life. People were encouraged and enabled to understand how to raise any concerns of safety. They did this by using systems and approaches that were adapted to meet their individual needs. Staff were equally supported and encouraged to raise any concerns of safety through supervision and staff meetings. There was also a comprehensive and up to date whistleblowing policy in place.

A relative told us, "Yes the service is safe, I'm really confident in what they do. Our family member regularly visits home and is always happy to go back". A health professional told us, "There has been nothing that has alerted me to feel people aren't safe in the service".

A staff member told us, "It's safe here, we follow legislation. Staff are well trained, pre-employment checks take place and it is company policy to review Disclosure and Barring service (DBS) checks on staff every three years". Another staff member said, "It is safe here, anything new is risk assessed. We all have to read and sign new risk assessments" they went onto say, "We reinforce safety around the home with information and support people to be involved in regular checks".

Staff were able to tell us how they would recognise if someone was being abused. For example, they told us they would look for changes in behaviour or sleep pattern, unexplained marks or money not adding up Staff told us that they would raise concerns with senior staff or management. Staff were aware of external agencies they could contact if they had concerns including the local authority safeguarding team and the Care Quality Commission. Staff told us that they had received safeguarding training and that it was regularly updated. We looked at the training records which confirmed this. There was a comprehensive local safeguarding policy in place and an accessible easy read version for people. People also had copies of the easy read staying safe guidance issued by the local authority. Whilst reviewing a person's care file we saw that they had stranger danger awareness training. This showed us that people were provided with essential information in accessible formats which were appropriate to their needs which enhanced their understanding and kept them safe and free from harm.

People had comprehensive person centred risk assessments in place which ensured staff understood people's wishes and desired outcomes. These detailed the activity being carried out, steps to take, the risks involved, control measures to follow to reduce the risks. Each activity had a risk rating. For example, one person's wish was to walk to the village shop independently and the desired outcome was, independence. Actions included wearing appropriate clothing and completing road safety training. The risks identified included tripping/falling. A few safety measures in place were to call for help and carry identification. The risk had been scored as low and the assessment was signed by the person and manager.

The registered manager told us that they sat with people who have capacity to create new and review their existing risk assessments. The registered manager said, "People are encouraged and supported to think about and say how they want staff to support them whilst identifying their own risks and thinking about measures that will keep them safe". One person lacked mental capacity and used non-verbal communication. The registered manager told us that they used observation with this person to involve them in assessing risks. The staff recognised mobility, body language, facial expression and sounds which were recorded and reflected in the person's risk assessments. This approach showed that the service supported people to manage and understand their own risks whilst being empowered to say how they wanted to be supported by staff.

Staff were made aware of reviews and new assessments to read through; staff meetings, open discussions with the senior and manager and messages left in the continuity book which staff read upon arrival to work. All staff were expected to read and sign these assessments. When reviewing these we saw that they had.

There were a number of general risk assessments which covered activities such as lone working, BBQ's, food, water temperature and the impact of seasonal weather conditions. We reviewed the health and safety records for the home. We found there was up to date information in place for staff which included the local policy and procedures for example; infection control, fire safety and lone working. Weekly health and safety checks took place by staff and people in the home. There was a staff template in use and a pictorial one for people which enabled them to carry out and record checks. The staff checks covered all areas of the home and recorded hazards found, actions taken with dates. The people's checks had been creatively designed and were visual. They categorized areas to be checked using photographs and plain English or (word) prompts. A person said, "Pictures and words help me understand information". We saw that people were also supported to complete first aid checks using another visual check sheet.

Actions identified during checks were recorded in the maintenance book. We saw that recently the outside light and heater in the conservatory were identified as not working. We were shown that these had been repaired and signed as completed. The registered manager said they also conducted regular environmental checks.

People had a Personal Emergency Evacuation Plan (PEEP). These plans detailed how people should be supported in the event of a fire. There was a standard plan by the front door and a pictorial plan for each of the people. We reviewed the fire records which showed that fire tests were carried out weekly using different call points around the home. Staff had received regular training and people were involved in regular fire evacuations. A person told us, "I know what to do if there was a fire. I have to meet in the car park". There was a fire risk assessment in place and this was up to date. There were emergency bags for each person by the front door. These bags kept torches, high visibility jackets, key information about the people for professionals and a change of clothes. The emergency plan covered potential emergency situations for example, floods, loss of power or a missing person. It listed contact numbers and guidance for staff to follow in such an event. We saw that all staff were required to read and sign this which each had done.

Incidents and accidents were analysed and trends identified by the registered manager and senior. The incident accident file contained the accident book and incident forms which evidenced the people involved, event which took place and the actions taken to manage it. The registered manager told us that this was reviewed monthly. We saw that a recent action following a trip on the step leading into the utility room resulted in a visual sign being displayed to remind people of the potential hazard.

The registered manager and senior told us that they used a staff dependency tool to determine staffing levels for the people. The home was predominantly a lone working service however; one person received 40

hours a week, Monday to Friday for one to one support. We reviewed the person's care plan which categorized these hours to ensure staff were aware of when and how the hours were to be covered. These hours included personal care, outings and activities. We reviewed four weeks of rota and saw that the rota was always covered and one to one hours were clearly identified. The manager told us they did not use agency staff but instead had their own bank staff that covered shifts during staff holiday, training, sickness or vacancies. The manager and senior arranged rota meetings when changes to shift patterns were needed for example, vacancies or maternity leave. The manager said that they sought staff feedback regarding shift patterns and where possible changes were made in response to it. This showed us that there was an appropriate consistent supply of regular staff supporting the people who lived at the home.

Recruitment was carried out safely. The staff files we reviewed had identification photos, details about recruitment which included application forms, employment history, job offers and contracts. There was a system which included evaluation through interviews and references from previous employment. This included checks from the Disclosure and Barring service (DBS). They also included induction records.

Medicines were managed safely. Medicines were securely stored in people's own rooms and only given by staff that were trained to administer medicines. Each person had an up-to-date medicine self-assessment in place which were reviewed every six months. These detailed the support people required to receive their medicines and identified whether they had the capacity to manage their own medicines. We were told that two people currently managed their own medicines. One person told us, "I administer my own medication; I ask staff to check it's the right time and day sometimes". We reviewed the medicine records including the Medicine Administration Record (MAR) sheet's and saw that they were completed correctly with no gaps or missed doses. The senior told us, "I complete weekly medication audits". The senior told us how they would manage a situation if they were to find gaps in MAR sheets or missed doses. This reflected the local medicines policy. New staff completed class room and e-learning training and completed medication competency checks on all staff before they could administer medicines.

Good

# Is the service effective?

## Our findings

Staff were knowledgeable of people's needs and received regular training which related to their roles and responsibilities. We reviewed the training matrix which confirmed that staff had received training in mandatory topics such as risk assessment and care planning, first aid, infection control and safeguarding, There was also training specific to people who used the service in topics such as epilepsy, downs syndrome and dementia. In addition to this all staff had achieved or were working towards their Diploma in Health and Social Care levels two to five.

The organisation provided all new staff with a staff handbook during their induction. It covered key topics examples included, attendance, benefits, policy summaries and code of practice. This supported new staff by giving them information and signposting them to relevant areas as and when required. One staff member told us, "I am offered enough training. Regard are very good at providing training". Another staff member said, "I complete all training and e-learning. Issues can be discussed in meetings which keep us all working effectively". Staff told us they discussed new learning with staff at the service and reflected on current practice. They said that they would share ideas with other staff and the registered manager.

The registered manager told us that supervisions were carried out with staff by them and the senior every month and appraisals took place annually. We were shown that topics discussed included, people using the service, staff role and accountabilities and performance. Records showed that supervisions were up to date and appraisals had been completed for this year. Staff meetings took place bi-monthly and covered areas such as people, activities and development.

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

Staff were aware of the MCA and told us they had received Mental Capacity training. The training record we reviewed confirmed this. We were told that three people had been assessed as having capacity and one person assessed as not having capacity. A staff member told us, "People with capacity will ask us to do something and give verbal consent. The person with no capacity would use preferred communication which may be through body language or gestures". Another staff member said, "One person does not have capacity to consent. Assessments are completed and best interest meetings take place". The care files we reviewed confirmed that capacity assessments were in place and that best interest decisions were made which included families and health and/or social care professionals. Care files had been signed by people who had capacity. The person who lacked capacity's had a Lasting Power of Attorney and the registered manager who managed decisions. A staff member told us, "as a way of obtaining consent I inform people of actions I am going to perform and ask them if they're happy for me to perform the task".

A person told us, "I can go to the shop on my own if I want to". Another person said, "If I want to go to the

shop, pub or walk on my own I can do and tell staff I am". 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. One person who lacked capacity and required one to one support in the community had a Deprivation of Liberty Safeguards application in process with the local authority. Three people did not require an application to be made.

People were enabled to be actively involved in the planning and creation of the menu. Menu planning meetings took place each week where people came together to look at healthy eating books, various recipes and think about what they would like to eat. Choices were recorded on a pictorial planning record which included ingredients and a shopping list. Each person took it in turn to cook meals and were involved in the food shop. One person told us, "I am involved in menu planning meetings but I don't always like talking about healthy foods, I like fish and chips". They went onto say "sometimes I like cooking other times I don't. I like cooking fish and chips". Another person said, "I cook here, I like it. My favourite dish is vegetable bake and pasta bakes". Another person told us, "I like food here; I cook tonight, fish and chips. I like chicken casserole. I take part in menu planning meetings and food shopping". We reviewed the menu meeting file and saw that information on healthy eating and guidance was up to date and readily available. We observed on several occasions people helping themselves to drinks.

People attended various day services throughout the week and took packed lunches with them. One person told us, "I take a pack lunch each day which I make".

People used health care services as and when this was required. People's files showed they attended appointments for various healthcare support for example, GP, district nurse and dentist. A person told us, "I am supported to hospital if I need to go by staff". Another person said, "I have a doctor's appointment this morning. I have to go to hospital soon. Staff will support me". A staff member told us, "People have access to regular health visits like, annual health checks, opticians and the dentist".

People were supported to be involved in the decoration, designs and adaptations in the home. One person told us, "I like my bedroom; I chose the colours and furniture". A person showed us the bathroom and said, "I was involved in choosing the tiles, it's nice isn't it".

The provider had agreed a budget to replace the existing laundry / sun room at the home. One person had asked for a breakfast bar to be fitted so they could have a choice of where to eat their breakfast. People had asked for the old shower room to be removed to create more space. These had been included on the new design in response to their feedback. We saw that people had also been involved in choosing flooring, lighting, cupboards and positioning of their new notice board.

Good

# Is the service caring?

## Our findings

The staff demonstrated positive caring relationships between them and people. Approaches used were person centred, innovative and empowering. This was shown by staff asking what the person wanted and by supporting people to make choices and decisions for themselves. A staff member told us, "I spent time with people when I started and joined in with activities they enjoyed. This helped me to get to know them and the things they like. It also helped me build a relationship with them". Another staff member said, "It's caring here. Its very person centred. We go above and beyond". The registered manager had a strong belief in person centred care and told us that making a difference to people's lives in way that suits them was her passion. A health professional said, "There is a very person centred approach used and independence is promoted".

A health professional told us, "Staff are caring, some people can get upset during health checks. Staff have a good understanding of their needs, likes and dislikes and ways to communicate with them". A relative said, "I always feel welcome at the service. I don't need to worry; I know my family member is in a good place".

We saw staff and management acknowledging people as they entered the communal areas on several occasions. People seemed comfortable in staff's company and often engaged in conversation. We observed people approaching staff openly and confidently throughout the course of the inspection which showed us that positive relationships were developed between people and staff. A person told us, "Staff care and help me when I need it". Another person said, "Staff are caring, my life is good now". Another person told us, "Staff care. If we have a problem we talk to staff about it". A staff member said, "Colleagues respect people. They have all built up rapport with them" they went onto say, "I put myself in their position and empathise with people". Another staff member told us, "We are all sympathetic and empathic to people we support".

The senior told us that information is made easy to understand by providing visual prompts and choices along with text. This enabled people to understand information and be able to make informed decisions and choices about their care and support. The senior told us, "We ask people to confirm decisions to check their understanding".

People's care and support files recorded key professionals involved in their care, how to support them and medical conditions to name a few. This information supported new and experienced staff to understand what was relevant about the people they were supporting.

People told us that their privacy and dignity was respected by staff. We observed doors being closed when personal care was being delivered. Locks were provided on communal bathrooms for people to use as they wish. People all had locks and keys to their bedrooms. A staff member told us, "I respect people and knock on doors. I make sure they have dignity with personal care". Another staff member said, "I respect people's privacy and dignity by closing doors and not talking about people in open places. I always wait for an answer when I knock on people's bedroom doors before I enter".

One person had a Do Not Attempt Resuscitation (DNAR) in place. People with capacity had completed an

end of life wishes plan. This captured what people's wishes were in relation to funeral arrangements for example, burial/cremation, music and headstone choices to name a few. These were all signed and reviewed with people regularly in case their preferences were to change. The registered manager told us that a plan had been sent to the Lasting Power of Attorney on behalf of a person who lacked capacity and that they were waiting for their response.

Good

# Is the service responsive?

## Our findings

People who used the service were encouraged and enabled to plan their own care and feedback to staff how they want to be supported. We reviewed people's care files which both had front read and sign sheets for staff to complete once they had updated themselves on any key changes and updates on the people. For example in one person's file it directed staff to a recent update of a risk assessment following an incident. Additional control measures had been introduced in response to the event occurring. A staff member told us, "Changing needs are reflected in people's care plans. We are required to read and sign that we have done so". Staff used a consistency book to communicate to one another. This captured messages and key information to each other, for example, arranged appointments, booked events and up dated paperwork to name a few.

A relative said, "Staff are very good, if our family member has a health need they act on it. For example they had an eye infection and were supported to the GP straight away. A filling fell out as well and our family member was supported to the dentist that day". A health professional told us, The service is very prompt at getting health concerns dealt with".

Care plans reflected people's history, what was important to them and what their likes and dislikes were. They covered key areas of care and support specific to the person they related to for example, one key area for a person was to stay healthy and safe. The plan clearly detailed what support the person required and gave staff guidance on how to provide this using person centred approaches agreed by the person. A key area for another person who had capacity was around behaviour. This explained to staff that the person wished to be given time to calm down and reflect before talking. A person told us, "I take part in my review meetings about my care, I am happy". Another person said, "Staff support me with my anxiety. I like to talk to them about things and take medicine. These help me".

The registered manager told us that people were actively involved in reviewing their care plans as well as the setting and achievement of personal goals. We reviewed people's goal sheets and saw that these were reviewed six monthly. Each sheet was visual and everyone had a copy attached to their notice board. As goals were achieved people put achievement stickers next to them. A person told us, "I am supported to make choices and decisions. I have been supported to get an iPad and phone recently". Another person said, "I have a care plan in the office. I choose my goals they are on the notice board. I set one which was to adopt a tiger through a wildlife charity. I have done this now and they send me updates". One person had a visit to an owl sanctuary and a spa day included on their goal sheet which we saw had been achieved. A person told us, "I set my goals; one recently was to visit Stone Henge. We went on the bus, had lunch and walked around. It was very cold and windy but I enjoyed it". A relative said, "The service is very focused on what people want. Our family member is part of their care planning, goal setting and review of their care".

The manager showed us that people's goals were evidenced in a scrap book which captured photographs and people's memories. We saw photographs of parties work, holidays and head massages to name a few. The registered manager told us that one person had arranged their own birthday party. They had been enabled to write their own invitations, create their own decorations, design the cake and choose the food.

The book evidenced this and showed that the party was a success.

One person with complex needs had been supported to apply and was eligible to join a motor scheme which met their complex needs. The person had their own car for staff to drive them to places of their choice. A staff member told us that on some days the person might get distracted or tired of day service and preferred a drive. We observed on three occasions the person being supported to use their car. From reviewing the person's care plan we saw that the expressions made and words 'car, car' were positive and happy.

We reviewed the Personal Development Outcomes folder which contained people's daily notes that were completed by staff. These logged events such as personal care, activities, goals, health and one to one hours for example. The information from these was gathered and discussed in monthly key worker meetings which people with capacity were involved in. Those who did not have capacity were supported by using observational techniques of body language and gestures as well as gaining feedback from their families. We reviewed the key worker meeting file and saw that the information captured for example, reasons for shortfalls or over achievement with their goals or areas of care and what action had been taken. We saw that one person had been refusing to brush their teeth and bite down on their toothbrush. Action taken included a visit to the local dentist and introduction of medicated toothpaste. The Personal Development Outcomes led nicely into the keyworker meetings which in turn led nicely into annual in house review meetings and if possible annual multi agency meetings with families, health professionals and care managers from the local authorities.

All of this showed us that people were actively supported to be part of the planning and review of their care and support. Areas covered and goals set were all responsive to people's own individual needs and wishes. A staff member told us, "Supporting people to fulfil and achieve their goals, dreams and aspirations whilst ensuring their happy is what this work is all about".

The service had made various positive links with the local community which encouraged and empowered people to be part of it. A person told us, "I go to drama club at the village hall. We are rehearsing for a play in June. I'm excited". The senior told us that people bake cakes for the annual street fairs and festivals. We saw that some people attended a local horse riding centre and church. The senior said, "Following the death of a person's parents they wanted a blessing. We supported the person to make links with the vicar who came to meet the person and arrange it. They were blessed in the village church". A person told us, "Staff helped me find a job at Costa. I wash up and clear tables. I have done it for a long time now and really enjoy it".

People were supported to attend a day service which was part of the organisation. This offered people the opportunity to take part in activities such as, woodwork, pottery and needle craft. A person showed us the weekly timetable which showed people and staff what people had going on each day. Activities included employment, rural skills, gardening, pottery, gym and outings with staff to name a few. A person said, "We sit down with our keyworker and choose activities and plan my timetable. We all have one". They went onto say, "I am going to woodwork today after my doctor's appointment". We saw that people also enjoyed social activities. A person told us, "I went out for lunch yesterday. I have gone to the beach, parties, cinema and bowling. I can choose if I want to go". Another person said, "I go to the cinema, out for lunch and away on holidays. I can choose what I want to do and where I want to go". We saw that activities were recorded in people's Personal Development Outcomes folder.

A staff member said, "People feedback to us through key worker meetings, menu planning meetings and resident house meetings". A person told us, "We have house meetings; I can tell staff if I'm not happy and they will deal with it". We reviewed the house meeting file and saw that these were taking place regularly.

These meetings enabled people to discuss topics such as maintenance issues, staff changes, key workers and activities. We saw that in the last meeting people had fed back that they liked a new staff member and that one person had said they wanted new blinds in their room. The registered manager told us that the keyworker was working with the person on this; they said that measurements had been taken and colours were currently being decided by the person. We saw that in another meeting a person had asked to change their activities at day service. The registered manager told us that this was now done and we saw that the person's timetable reflected this. We observed a person inform the registered manager that their hot water tap was not working. We saw that this was recorded and that the registered manager had arranged for a plumber to fix it the day after the inspection. This demonstrated that there was a prompt response to feedback given by people.

Complaints, concerns and suggestions were used in a positive way to review and develop the service. These were well managed and seen as a means of understanding how to improve people's experiences. There had been no formal complaints made to or recorded by the service since our last inspection. The service had a complaints review log in place which captured complaints and reflected the steps taken to resolve them. In addition to this the service had a feedback book which logged people's grumbles. We saw that the last one involved a dirty toilet. In response a house meeting was called where everyone agreed to clean the toilet after using it. There was a complaints policy in place and up to date with steps to take and contact information available. People had an accessible version called 'speaking out' this used pictures and text which supported people to understand it. A relative told us, "I would take complaints to the registered manager but I've never had too. I am confident that the registered manager would manage it. I may take a complaint to the social worker too but I can't see that ever happening".

People were given the opportunity to complete three monthly feedback questionnaires. Questions included, rooms, any changes, staff and the environment to name a few. Actions were logged and planned. We saw that one person had feedback saying that they wanted book storage in their room and that this activity had been arranged for the following day.

The organisation sent out annual surveys to people, relatives and professionals. Results were analysed and reports created. We reviewed the 2014/15 results and saw that the majority of feedback had been positive and encouraging. One person had fed back that they were not aware of the services CQC report. The registered manager showed us that they had since sent each relative a copy of the last report. We read one comment which said, "My family member is happy and well looked after. They will say if their needs aren't met". A relative told us, "I receive annual questionnaires and complete them. I believe feedback is responded to".

Good

# Is the service well-led?

## Our findings

We observed a positive culture between people and staff supporting them. The organisation had a person's charter in place which reflected their beliefs and people's rights. We observed on several occasions people's rights being respected in line with the charter in areas such as, privacy, involvement, choice and decision making to name only a few. The registered manager demonstrated a true belief and strong passion for a positive culture that was person centred, inclusive and empowering. The registered manager told us that they strive and are committed to people. They said, "As a manager I understand paperwork and want to make it as person centred as possible. I am passionate about making a difference. It's important we enable people to lead their own lives, it's all about people. To do this I need a good team who are well trained, clear systems in place and to understand current and any new legislation".

A person told us, "I like the manager. They are helpful". Another person said, "The registered manager is a good listener and helps people. The senior is a really good worker too". Another person said, "I know the manager. I like them". A staff member told us, "The registered manager shows respect to staff and people. She talks to people and staff. She listens to us and is open to suggestions and supportive of new ideas". They went onto say, "The registered manager is good at thinking on their feet. If we go to them with a problem they are good at finding a solution". Another staff member said, "The registered manager is a great leader. They are a good communicator. Great mentor and promotes personal development". They went onto say, "The registered manager is supportive, flexible and listens to us".

A health professional told us, "The service is well managed. The registered manager is very accessible. Reviews are regularly arranged and appointments booked". A relative said, "The service is well managed. My experience to date has been fantastic".

There were systems in place which made sure that the care and support being delivered to people was of a high quality and was able to constantly develop. The registered manager told us they had a manager's check sheet in the front of each folder which they completed monthly. We reviewed these checks and saw that they covered updates, staff signatures, outstanding actions and reviews to name a few. The registered manager said that this was one system they used to monitor quality care provision. We reviewed other quality checks for example, medication audits, health and safety audits and infection control. We saw that these took place regularly and that actions were captured and acted upon within a reasonable timeframe. A staff member told us, "Lots of different checks take place here like, vehicle safety checks, temperature checks and audits".

The registered manager told us that the organisation sends internal auditors into the home to review practice and record keeping. We saw that the locality manager attended some activities recently at the service. The registered manager and senior told us that they liked how the locality manager came to the service and talked to people first.

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken

place in them.