Leonard Cheshire Disability

Birnbeck House - Care Home Learning Disabilities

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 29 and 30 November 2016 and the first day was unannounced.

Birnbeck House provides accommodation and personal care for up to 13 people with learning disabilities. It is large Edwardian style house located in a residential area of Weston-super-Mare within easy reach of local amenities, the town centre and the beach. The home supports people who are highly dependent but also has facilities for more independent people.

There is 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.

Where records were duplicated, for example completing bowel charts, staff did not always record information accurately. Where additional records were required, such as monitoring a person after a head injury, these records were not completed. .

Relatives told us people were kept safe and free from harm. There were appropriate numbers of staff employed to meet people's needs and provide a flexible service.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Systems, processes and standard operating procedures around medicines were reliable and appropriate to keep people safe. Monitoring the safety of these systems were robust.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. The risk assessments we read included information about action to be taken to minimise the chance of harm occurring.

Staff knew the people they supported and provided a personalised service. Care plans were in place

detailing how people wished to be supported and families were involved in making decisions about their care.

People were supported to eat and drink. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet people's needs.

Staff told us the registered manager was accessible and approachable. Staff and relatives felt able to speak with the manager and provided feedback on the service.

The registered manager undertook spot checks to review the quality of the service provided and made the necessary improvements to the service. Regular audits were completed.

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 protected from the risk of abuse and staff were aware of safeguarding vulnerable adult's procedures.

People had risks to them assessed and plans were in place to manage these risks. There were processes for recording accidents and incidents.

People were supported by enough staff to meet their needs.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink according to their plan of care.

People were supported to attend healthcare appointments and staff liaised with other healthcare professionals as required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were knowledgeable about the care people required and the things that were important to them. Staff were able to tell us what people liked to do and gave us examples of how they communicated with people.

People's privacy was respected by staff. People responded well to staff and we saw positive interactions between staff and people using the service.

People were able to access local advocacy services to support them if required.

Is the service responsive?

Requires Improvement

The service was responsive to people's needs, but staff did not record this accurately.

People received personalised care and support which was responsive to their changing needs; however records were not maintained to reflect this.

People were supported to take part in a range of social activities in and outside the home.

People were supported to give their views about the service they received. The registered manager had listened to what people said and made changes.

Is the service well-led?

Good

The service was well-led.

Staff were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

The registered manager and the provider checked the quality of the service provided and made sure people were happy with the service they received.

Birnbeck House - Care Home Learning Disabilities

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 29 and 30 November 2016 and the first day was unannounced. It was carried out by an adult social care inspector 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.

Before the 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 looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

People had communication difficulties associated with their learning disabilities. We observed staff interacting and supporting people in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During our inspection we spoke with two people who lived in the home, four care staff and one senior care worker. After the inspection, we spoke with four relatives and one healthcare professional. The registered manager was not available when we visited the service therefore we spoke with them following the inspection. We looked at the care records for four people and pathway tracked two people. We also looked at records that related to how the home was managed, such as minutes of meetings, training records, four staff files, emergency procedures and a variety of audits.

Good

Is the service safe?

Our findings

The service was safe.

The provider had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Whistleblowing is a way in which staff can report concerns within their workplace. Staff were aware of the provider's safeguarding policy and told us that they knew how to recognise and report concerns they might have about people's safety. Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff told us, "There are several forms of abuse like physical, mental, financial, etc. It is something not nice and shouldn't happen" and "If I witnessed abuse taking place I would intervene and stop it, make sure the person using the service is OK, then report immediately to the senior support worker or the manager." Staff also said, "If I needed to, I know I can report to the safeguarding team, police and CQC." All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Risks of abuse to people were minimised because there was a safe recruitment procedure which had been followed. Checks to make sure staff were safe to work with vulnerable adults were carried out before they started work which included, employment history, references and criminal record checks.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. We saw there were three carers on duty with one senior and the registered manager during the daytime. Additional staff escorted people to activities in the community. Domestic staff and a cook were additional to these numbers. At night there was one waking staff and one sleeping staff. Staff rotas confirmed these staffing levels. Staff told us, "We're never short of staff" and "We phone around other staff if anyone's off sick." Staff told us there were always staff with a range of skills available. Staff said, "Yes definitely we share skills and work as a team to care for the guys". Staff told us everyone had one to one time, especially when they were being supported with activities. We asked how many people were funded specifically for one to one or two to one support; this information was not available. The provider used a spreadsheet which recorded the core hours each person required to calculate the number of staff needed, but this did not identify when people should receive one to one support.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff on duty took immediate actions to deal with any accidents or incidents. Information was then sent electronically to the person responsible for health and safety at the organisations head office. They then informed the registered manager of any further action they needed to take. The registered manager confirmed when this had been completed. Where people had suffered any injuries we saw these were recorded and monitored until any wounds had healed.

Risk assessments were in place to support people to be as independent as possible. These protected people

and supported them to maintain their freedom. Risk assessments considered 'What the risks are', 'Actions to take' and 'Timescale of review'. Each of the risk assessments was linked to a support plan and encouraged positive risk taking rather than limiting what people were able to do. For example there were risk assessments for bike riding and travelling in the car, enabling people to do these activities safely. Staff knew about the assessments and protocols in place to protect people.

Epilepsy guidelines and risk assessments gave clear guidance for staff of the measures in place to reduce risk. Where people had epilepsy, staff monitored the person and recorded information about their seizures and any treatment given. This was important so healthcare professionals could have up to date and accurate information when considering any changes the person might need to manage their condition. Staff had received specialist training for epilepsy and administering any rescue medicines.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. One member of staff told us how they would follow the fire procedure; this was in line with the guidance. Records were kept for staff attendance at fire drills. These records were based on the date of the fire drill and listed staff who had attended. The home's policy was for day staff to attend a fire drill every six months, and night staff to attend fire drills every three months. We checked and saw night staff had completed the training in the required timescales; however to check all day staff had also completed the required training was not possible because the records did not facilitate easy retrieval of this information. This meant it was difficult for the provider to have an overview as to who had attended fire drills as records did not facilitate this easily. The home had an arrangement with a sister home where they could evacuate people in the event of an emergency. Personal emergency evacuation plans were in place which gave staff information about the support people needed, as well as any specialist equipment people might need to help them with any mobility needs. We saw the fire risk assessment was dated November 2010; this had been reviewed annually until 2014. After the inspection, the registered manager provided the updated risk assessment which was completed in November 2015 and had just been reviewed.

We noted that all the Medicine Administration Records (MAR) had photographs of the person on them. One person's photograph had not been updated because it showed the person with darker hair and looking much younger. Up to date photographs ensure that any agency or new members of staff who may be unfamiliar with the person are able to recognise that it was the correct person when dispensing medicines.

Peoples' medicines were managed and administered safely. No one was receiving covertly administered medicines and no one was self-medicating, though the providers medicines policy contained the process for staff to follow should this be necessary. Some people were prescribed medicines on an 'as required' basis. People had care plans in place which detailed the medicines the person needed and how best to support them with this. The care plans explained what the person would do if they didn't want to take their medicines, and what staff should do if this happened. Two people told us, "I get my medicines on time and I know what all my medicines are for" and "I have help with my medicines and inhalers and I have all my medicines stored in a temperature controlled locked cupboard in my room which I am happy with." People told us they trusted the staff. Staff told us, ""We get extra training around things like controlled drugs and how to administer rescue medication that might be required."

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were

appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. Current medicines guidance was available online and via the patient information leaflets which accompanied the medicine. This meant staff had guidance available for monitoring people for any side effects of taking medicines. We saw records for one person which showed staff had not completed the required chart when they used a soap replacement cream. In 12 days, the records had not been completed four times. We saw minutes of staff meetings where staff had been reminded about completing records for topical medicines.

A master signature list was available; this ensured that in the event of an error the dispensing practitioner could be quickly identified from the MAR chart initials. Fridge and room temperatures had been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes. This meant there were safe medicine administration systems in place and people received their medicines when required.

We observed that the premises were clean and odour free during our inspection. Staff were observed washing their hands before handling food and wore appropriate gloves and aprons. Disinfectant hand gel was available. Good staff hand washing signage was prominent in the staff toilet, emphasising the importance of correct hand washing techniques and the importance of hand washing to prevent the spread of infections.

One person living in the home had a confirmed infection. Information in the person's care plan gave clear guidance around appropriate precautions to prevent the spread of infection. Staff we spoke with were aware of the person's condition and knew how to minimise any risks.

The water hygiene file showed evidence of calorifier disinfection, water tanks and water heater checks being completed annually. Records of shower head cleaning were also in place and Legionella water hygiene logs had been completed.

Good

Is the service effective?

Our findings

The service was effective.

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. Staff told us, and records confirmed that all staff had completed an induction. This provided them with the basic skills and training needed to support the people who lived in the home. The induction programme was linked to the Care Certificate. The Care Certificate standards are set by Skills for Care to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People's needs were met by staff who had access to the training they needed. Staff had received training which included safeguarding, medicines and moving and handling. Staff told us they had the training and skills they needed to meet people's needs and records confirmed this. Staff were supported to complete specialist training such as epilepsy and supporting people who needed to be fed via a tube. Staff were also able to complete nationally recognised training courses such as level 3 diplomas. Staff confirmed the training they received enabled them to understand what was expected of them and how they should provide the care and support people required. For example, staff said, "You need to have health and safety training to be able to use the equipment" and "Training increases our knowledge about what to do in certain situations". Relatives told us, "Staff are well trained, they know peoples foibles and are very person centred."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Activities and appointments people had engaged in were recorded on handover forms, as well as comments about people's observed health. Staff told us, "We discuss every service user. For example following a shift the staff would handover any personal care that was given, if the service users had an unsettled night, if on call was contacted for any reason and any activities or appointments that they may have needed to attend; also anything out of the ordinary." Another member of staff told us, "We discuss information about food intake and if anyone has had a seizure". This meant any changes to people's health were identified quickly and appropriate communication could be shared with healthcare professionals.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff said, "Supervisions give us the opportunity to discuss any training needs, reflect on certain situations we might have found ourselves in that were new " and "It's an opportunity to raise any concerns or issues we want to raise". Staff told us and records confirmed staff were given annual appraisals. Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required. All staff told us they felt supported by the registered manager, and other staff.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people

who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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 told us, "I would follow policy guidelines if necessary" and "All of the people that use the service that have required this process have the information in their care plans for staff to follow and refer to."

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).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. We 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. 11 of the 13 people living in the home were subject to DoLS authorisations. We saw one person was subject to DoLS authorisation with a condition attached; this was to review the person's medicines. This review had taken place within the timescale identified. Where people's finances were overseen by the Court of Protection; we saw this information was recorded in people's care plans and was being followed.

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. A "best interest" meeting is a multidisciplinary meeting where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves. Best interest decisions had been completed for activities such as the treatment and support people needed, who information could be shared with, decisions around finances and taking medicines. Healthcare professionals such as GP's were involved in these decisions, together with families where appropriate. One person had a resuscitation decision record following a best interest meeting with a GP.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Staff told us they had all the information they needed and were aware of people's individual needs. For example, we saw some people required special textured diets so they could swallow easily; this was clearly described in their care plans and we saw that these were provided as required. Where necessary, people were provided with appropriate equipment, such as plate guards, to enable them to eat independently. For example, one person's care plan described a two plate system so the person could be given a small amount at a time, but several portions.

People were able to make their own choices about the meals they ate and staff knew how people would make these choices. People were either asked or shown the meals and made a choice of what they would like. People said if they weren't happy with the menu for the day they could have something else. People were able to have takeaway food and enjoyed fish and chips on the first day of the inspection. At lunch time people were able to choose where they ate their meal. One person said, "I am very happy with the menu and food here. The staff help me with not having any sweet things and I am offered lots of different foods with salad". One person told us if they got hungry or thirsty they would tell a member of staff, who would assist them with getting a snack or a drink.

Where necessary, people were supported on a one to one basis at mealtimes. Risk assessments identified any risks to the person such as a risk of choking. Where people were at risk of choking, food and drinks were prepared in line with Speech and Language Therapist guidelines. We observed staff assisted someone to eat; this was done appropriately and staff enabled people to be as independent as possible and offered support where required.

The PIR said two people had required special tubes to be fitted for feeding due to their health issues. Staff received specialist training for this to ensure they could continue to support the people to stay in the home. A healthcare professional said, "They're great, they follow guidance, contact me to update any information and I have no concerns."

Staff training certificates showed that they had completed food hygiene training. The home had been awarded four stars in a food hygiene inspection in May 2016. Staff we spoke with confirmed they had completed food hygiene training.

Food and fluid charts showed that people's intake of nutrients was being recorded where required. The charts recorded what people had eaten and drunk, but not the amounts. It is important to monitor the amount people are eating and drinking to help monitor their health and be able to intervene quickly to correct any imbalance before people become ill. People's weights were recorded on a monthly basis unless otherwise stipulated. The senior care worker explained that should anyone be observed losing weight, they would be referred to a GP who in turn would refer to a dietician. Other reasons for weight loss would also be investigated if necessary.

House meetings were held monthly where discussions around menu planning, news and events and staff teams were held with people by using picture cards. An addition to the menu had been made following one of these meetings. Staff told us, "People could refuse to take part in these meetings if they wished."

Some people living in the home had complex needs and required support from specialist health services. People had a health action plan which described the support they needed to stay healthy. Care records showed people received support from a range of specialist services, such as GP's, Speech and Language Therapists, Physiotherapists and dentists. One person told us, "Staff will contact the doctor and give me medicines if I need it." One person was supported by nurses from a hospice. Where another person had no family to be involved, staff had made suggestions what they thought the person would like for their end of life care, such as classical music and pan pipes.

Good

Is the service caring?

Our findings

The service was caring.

From our observations, we could see that people were relaxed in the presence of staff and appeared to be happy. Staff were attentive and had a kind and caring approach towards people. For example, we saw one person enjoyed holding a carer's hand while they supported them to have a drink; the person was quite content with this. One person told us, "I like them to be honest with me like I am honest with them; I love it here." Relatives told us, "Care is exceptional", "They're brilliant" and "Of all the places our relative has been in, and there are quite a few, this is the most satisfactory and caring place he's been." Staff said, "Meeting [people's] needs is following what they like and dislike, always being happy, chatty and friendly towards them. If you're down they will sense it" and "If I saw another member of staff ignoring the service user and not meeting their needs I would ask them to come into another room and discuss what I have just seen and explain how it affects others."

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. People's privacy was respected and all personal care was provided in private. Staff told us, "We have had all of that training and maintaining their privacy and dignity is about keeping them from being exposed during personal care." Staff were seen to ask peoples' permission before they supported them. Staff explained what they were doing before they did it. For example, one person required support when being fed through a tube. Although the person was unable to respond verbally the member of staff explained the process to them. A dignity screen was used to give the person privacy during this process.

Staff understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. People told us staff respected their culture and diversity. One person was supported to attend church regularly; they told us, "I go to church every other Sunday". There was an equality and diversity policy in place and staff completed training in this. Care plans recorded people's personal history together with their needs and preferences. Staff were aware of the information in people's care plans.

Staff were deeply committed to providing additional sources of enjoyment for people. Staff had engaged in several fundraising efforts and were in the process of raising a substantial amount of money which they wanted to be used to create a sensory garden for people to enjoy. People were supported to maintain contact with friends and family. The registered manager had also been able to contact long-lost family for two people; the families had been supported to become involved in people's lives after years of not knowing anything about their relatives. Feedback from one relative included, "They helped locate my brother after he had moved to another location and his former manager did not bother to let me know. I am very pleased with the communication I have received." Staff kept relatives living abroad up to date with their loved ones. Relatives told us, "We are able to maintain contact, it's nice" and "We're more than happy about the way they keep us in touch." One person was supported to attend a surprise birthday party for their mother.

People's bedrooms were personalised and decorated to their taste. One person told us, "I like my bedroom because my brother chose it". People were able to choose where they spent their time. One person told us, "I can go to my room if I want but I prefer to be around people as you get to know them, I like the atmosphere."

All visitors had to ring a doorbell and be invited in by a member of staff. Every visitor was asked to sign the visitor's book when they arrived. This meant people were able to have visitors but were kept safe by staff.

Staff knew people's individual communication skills, abilities and preferences. For example, when one person was being assisted to sit at the dining room table, staff and the person both said, "Wiggle, wiggle" as the chair was being moved. This helped the person to be confident with the support they received and removed any anxiety they may have had.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. The home had links to local advocacy services to support people if they required support. For example, we saw advocates had been present at meetings where people's care plans had been reviewed. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. One member of staff said, "We understand about their human rights and how important it is not to talk about their personal information outside of work." People's documents were stored in the office or in a locked cupboard. The office was always occupied by members of staff, but if required could be locked. By doing this people's private information was protected from being seen by unauthorised parties.

The provider has signed up to the Department of Health's initiative 'The Social Care Commitment.' This is the adult social care sectors' promise to provide people who need care and support with high quality services.

Requires Improvement

Is the service responsive?

Our findings

The service was responsive to people's needs, but staff did not record this accurately.

The home was involved in a pilot scheme organised by the community team for people with learning disabilities. The project involved staff completing an 'Anticipatory Health chart'. Staff told us and records confirmed they completed an e-learning course before they were able to use the chart. The chart recorded different aspects of the person's health and its purpose was to try to identify any physical changes that could identify an underlying a health concern for the individual, with the aim of preventing hospital admissions. Feedback from the health professionals implementing this scheme were that the home engaged very well and volunteered to participate.

People's care records did not always contain accurate or complete information. There were some discrepancies between records where information had to be recorded in multiple forms. For example, one person had a risk assessment which identified they could become agitated when they were constipated. Staff therefore completed bowel charts for this person. The bowel charts and the 'Anticipatory Health Chart' contained conflicting information about whether the person had had their bowels open for two days running. This was pointed out to the senior on duty, who acknowledged the conflicting information. This person's care plan also contained conflicting information about how they needed their drinks prepared. One record stated they needed their drinks thickened so they could swallow it without choking; another record stated they drank normal fluids. All staff knew the person needed their drinks to be thickened.

A GP had requested 24 hour observation for one person when they sustained a head injury. We asked the senior on duty for these records, but they had not been completed. The daily notes showed the person had had a settled night and had enjoyed an activity during the following day. The risk assessment for this person said extra monitoring should be put in place when they were agitated. Their records stated the person was agitated two days after they sustained the head injury, but records did not show extra monitoring had been put in place. Staff knew about the person's head injury and were able to reassure us they had observed the person for any signs of deterioration.

We found one person had two medical conditions which had not been a recorded risk assessed or care plan to inform staff; however the lack of risk assessments or care plans did not put the person at risk. We drew the registered manager's attention to this and they said they would deal with this immediately.

People's needs were assessed before they began to use the service and reviewed regularly thereafter. People's assessments considered all aspects of their individual circumstances such as their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. People or their relatives were involved in developing their care, support and treatment plans from the initial assessments. Relatives told us, "They listen to what I say" and "They invite me to care plan reviews." Care plans were personalised and detailed daily routines specific to each person.

Relatives told us, "They understand people very well" and "They're very good at putting things in place." A

one page profile was available for staff which gave information about what was important for the person, things people liked and admired about them and things staff needed to know or do to be able to support the person. For example, one person's profile said it was important for the person that they were able to look out of their bedroom window at night. Staff we spoke with were aware of this.

One person's communication care plan identified the person's preferred methods of communicating, and what facial expressions meant. Communication charts recorded what the person did in certain circumstances and what staff should do to support the person. For example, when one person pulled at their clothes, this meant they wished to change. Care plans identified how people were able to show they were distressed or in pain. For example, one person's care plan said they would show distress by flicking their hand. Staff knew these signs and were able to tell us what they did when the person was upset. The daily notes seen recorded were factual and referred to people in a respectful manner.

Monthly summaries were written for each person by their key worker. These were used to review how effective each person's plan of care had been and to note any significant events. A key worker is a named member of staff who was responsible for ensuring people's care needs were met. Key workers reviewed the people they supported and ensured the person had access to annual health checks, eye checks and dental appointments. Relatives told us they knew their loved one's key worker by name and felt the communication between them was good.

There were behaviour plans in place for some people. These identified how staff should respond to any behaviour which they found challenging. This may include aggression to staff or others, distress and agitation. There were specific plans that identified trigger points for people's challenging behaviour. These plans described how best to manage their reactions and behaviours, for the benefit of all people in the home. For example, one person's care plan identified they could become agitated when exposed to noise, too many people around them and when there was a lot of activity around them. The persons care plan explained how to prevent the person becoming agitated, and what staff should do to support the person if they became agitated. Staff were able to explain what might cause the person to become agitated and knew how to support them if so.

People had been assisted to complete key information documents about "what is important to me"; "what others like and admire about me"; "how best to support me"; and "what else you need to know". The information in these documents was held together with a summary of health needs and were sent with an individual when they attended hospital.

The care staff we observed supporting people clearly knew them well and understood their needs. Relatives told us, "They understand [name] very well" and "Staff told us they read and contributed to care plans and risk assessments. They were told immediately of any changes to a person's plan. One staff member said "We know each person really well. If anything changes this is always discussed at handovers, team meetings and we have a communication book as well." People were supported to maintain their independence. One person told us, "They do get me to do things myself. I do my washing and drying and I am able to wash myself and the carers will do the bits that I can't do."

The service was flexible and responsive to people's social needs and found creative ways to enable people to take part in activities and access the community. One person was supported to go swimming on the day of the inspection. People were involved in rehearsals for a pantomime; one person told us about the part they were playing. Relatives told us, "They seem to take people to places I'm quite surprised at, such as the theatre, walking and on holidays" and "It's brilliant, [name] is very happy there." Other comments included, "We're really happy because [Name] is beginning to join in things, for two years they wouldn't do anything."

During our inspection we observed a reading club activity taking place in the communal lounge. A member of staff was reading a book to five people who were relaxing in their chairs. Other activities included reflexology, pamper and sensory sessions, various clubs, hydrotherapy and 'in 2 biking', where people were able to ride specially adapted bicycles, cooking clubs and other outdoors activities. Risk assessments for activities gave clear guidance for staff about the level of support people needed to access activities with minimum intervention, and ensured people were encouraged to take positive risks. People were supported to take part in holidays, for example some people went to a holiday camp in 2015.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. For example, the results of the survey completed in 2015 were posted on the notice board together with the actions the registered manager had identified from the survey. People had commented they didn't know how to access support externally, so the registered manager added this information into various meetings such as residents meetings. People also wanted more opportunities to air their views; as a result, more review meetings were being held and people were able to have one to one time to share their views. Families had been given the opportunity to air their views in September 2016. Comments included, "I….am able to maintain contact via email. Communication regarding health, activities and likes/dislikes is excellent."

People and their families had been made aware of the complaints procedures. Information was available in easy read formats so people could understand them. One person told us they were able to tell staff if they had any concerns and referred to their two keyworkers. They said, "I can speak to two key staff in particular or any member of staff." Relatives told us they had no concerns or complaints. One relative said, "I can't fault either the staff or the care." Information about complaints was entered onto the provider's computer system and sent to the organisations head office electronically. This was then allocated back to the manager who was expected to respond within a timescale. Complaints were analysed to identify patterns and trends. Complaints had been investigated thoroughly and people and their relatives were satisfied with their responses. Complaints booklets were seen displayed on the noticeboards around the home and by the front door, and people were reminded how to raise concerns during regular meetings.

There were regular meetings for people who lived at the home and their relatives. The last meeting for people using the service had been held in November 2016 and people had been asked for their views about activities. Minutes of the meeting were available in easy read format and had been posted on the notice board.

Good

Is the service well-led?

Our findings

The service was well-led.

There were audits and checks in place to monitor safety and quality of care. Information in the PIR stated the home received out of hours visits which were conducted unannounced every three months by the service manager. We saw the minutes of the last out of hour's unannounced visit, which the registered manager conducted shortly before our inspection in November 2016. The report commented on the care and support observed, the conduct of staff, the environment and general observations. Quarterly monitoring visits were conducted by other service managers as part of quality assurance. The last audit report was completed in August 2016 and followed similar methods to CQC inspections. The auditor had rated the home 'Good' overall. Other audits had been completed, such as medicines audits, kitchen audits and health and safety audits. Where actions had been identified, these had been completed. For example, one audit identified risk assessments needed to be referenced in care plans. As a result we saw, for example, the risk assessments for using the vehicle had been linked to the care plans for leisure. The issues we found around poor recording occurred very recently in November 2016; as no care plan audits had been due at this time the registered manager had not had the opportunity to identify the shortfalls.

There were a number of maintenance checks carried out weekly and monthly. These included checks of the water temperature, equipment such as wheelchairs and vehicles as well as safety checks on the fire alarm system and emergency lighting. There were up to date certificates covering the gas and electrical installations, portable electrical appliances, any lifting equipment such as hoists and the stair lift.

The registered manager had a clear vision and values for the home which were documented in the statement of purpose. These included valuing the individual, working together with people, generating trust with stakeholders, being creative and ambitious. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff were aware of the values of the organisation and said this involved, "Looking after all of the service users, the home, all the staff being happy and that the home is clean and safe."

There was a staffing structure in the home which provided clear lines of accountability and responsibility. Everyone we spoke with felt the registered manager was approachable and fair. Relatives told us, "The service is very well led" and "The manager is very approachable." Staff said, "She goes above and beyond and values us", "The manager is very involved. She is here all the time except for when she is at meetings, she is very hands on, talks to the service users daily and her door is always open" and "I think the service is fantastic, well managed, a nice home, friendly, well led, people are looked after and all needs met." Other comments included, "I feel I can always go and talk to my manager, she is very supportive" and "My manager is appreciative and encourages us to do well and always thanks us for working hard."

Records showed a variety of meetings were held, such as service user meetings, staff meetings and senior

staff meetings. The registered manager also attended manager's meetings. Staff confirmed there were frequent team meetings held and said they found them informative. Staff told us the registered manager gave notice of any meetings with an agenda attached, and staff could add topics they wished to be discussed to the agenda. Meetings covered topics such as ideas for activities, the Christmas pantomime and any professional meetings held. Staff also told us there was always an opportunity for staff to be recognised and praised for things that had gone well.

All accidents and incidents which occurred in the home were recorded and analysed. We saw the system used was able to produce reports to identify trends and produce information in various graph formats. The PIR said Leonard Cheshire Disability used a shared learning approach and the home received alerts from other homes relating to health and safety and safeguarding incidents, if it was felt it could reduce the risk of incidents elsewhere. We saw the shared learning information sent to the home. Examples of the shared learning was that an induction process had been developed for agency staff and safe practices shared to prevent needlestick injuries. This meant the provider used data they collected to reduce the likelihood of accidents and incidents occurring.

Periodic monitoring of the standard of care provided to people funded via the local authority was also undertaken by the local authority's contract monitoring team. This was an external monitoring process to ensure the service met its contractual obligations to the council. We contacted the contract monitoring team after our inspection and there were no major concerns highlighted. The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. We used this information to monitor the service and ensure they responded appropriately to keep people safe.