# Progress Housing

# Lulworth

## Inspection report

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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

The inspection took place on the 12 July 2016 and it was unannounced.

Lulworth is a residential home registered to provide accommodation and personal care for up to 16 people. At the time of our inspection there were 15 people living at the home. Lulworth provides support for people with learning disabilities, people on the autistic spectrum and people with physical disabilities. Some people may have additional mental health issues.

A registered manager was in post and had been registered since June 2011. 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. They told us they will be de-registering from Lulworth to focus on a home owned by the same provider, which is next door to Lulworth. The registered manager and newly appointed manager were both present throughout the inspection. The newly appointed manager had worked within the homes since 2010 and was appointed to the manager position in June 2016. They were about to apply to become the registered manager.

Lulworth is situated in walking distance from Worthing seafront, within close proximity to shops and other town amenities. Lulworth has one registration with the Care Quality commission however comprise two separate buildings named Lulworth and a smaller annex named Blake. Lulworth, the larger of the two buildings, accommodates 10 people; bedrooms were spread out over two floors. Communal areas included an open plan lounge leading into a dining area. Blake accommodates 5 people. Corridors were spacious and people who used wheelchairs were able to move freely and independently around both buildings. An attractive patio garden divides the two buildings and is easily accessible for people.

We found both buildings were clean, homely and had a friendly atmosphere. The ambience of the home was warm and inviting. Photographs of people were hung in communal areas and corridors throughout were decorated with items which were personal to people who lived there including craft items they had made. People styled their own bedrooms therefore each one was personalised and unique.

People told us both homes provided a safe service and there was enough staff to meet people's needs. Staff were able to speak about what action they would take if they had a concern or felt a person was at risk of abuse. Risks to people had been identified and assessed and information was provided to staff on how to care for people safely and mitigate any risks.

People's medicines were managed safely and administered by staff who had received specific medicine training. The home followed safe staff recruitment practices and provided a thorough induction process to prepare new staff for their role.

Staff implemented the training they received by providing care that met the needs of the people they supported. Staff received regular supervisions and spoke positively about the guidance they received from both managers.

Staff understood the requirements under the Mental Capacity Act 2005 and about people's capacity to make decisions. They also understood the associated legislation under Deprivation of Liberty Safeguards and how to minimise restrictions to people's freedom.

People could choose when, where and what they wanted to eat and were encouraged to be as independent as possible with their meal preparation. Additional drinks and snacks were observed being offered in between meals and staff knew people's preferences.

Staff spoke kindly to people and respected their privacy and dignity. Staff knew people well and had a caring approach. People were involved in recruiting new staff to join the team.

People received personalised care. Each person was involved with their own care plan supported by keyworkers and managers. Care plans reflected information relevant to each individual and their abilities including people's communication and health needs. People were encouraged to pursue their own interests and accessed a range of activities within the home and in the community.

There was a complaints policy in place. All complaints were treated seriously and were managed in line with this policy.

People were provided opportunities to give their views about the care they received from the service. Some people chose to use these opportunities to become more involved with their care and treatment. Relatives were also encouraged to give their feedback on how they viewed the service.

Managers demonstrated a 'hands-on' approach and knew people well. Links with health and social care professionals had been developed to meet the needs of people.

A range of quality audit processes were in place to measure the overall quality of the service provided to people.

We made a recommendation to the provider in the Caring domain about how elements of their caring and person-centred practice could be developed and embedded further to demonstrate sustained 'outstanding' practice.

## 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 and their relatives felt the service was safe. Staff were trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient numbers of staff and the service followed safe recruitment practices.

People's medicines were managed safely.

### Is the service effective?

Good

The service was effective.

People's care needs were managed effectively by a knowledgeable staff team that were able to meet people's individual needs.

Staff received regular supervision and appraisals. Training was provided and refresher courses were booked.

People received support with food and drink and made positive comments about staff and the way they supported them.

Staff understood how consent to care should be considered.

The service made contact with health care professionals to support people in maintaining good health.

### Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and respectful staff.

People were provided with many forums to be able to express

their views and be actively involved in making decisions about their care.

Staff knew the people they supported and had developed meaningful relationships.

## Is the service responsive?

Good

People received personalised care from staff.

Care plans were individual to the person.

People were encouraged to pursue their own interests and accessed a range of activities within the home and the community.

People knew how and who to complain to if there was a concern about the care they received.

## Is the service well-led?

Good

The service was well-led.

The culture of the home was open, positive and friendly. The staff team cared about the quality of the care they provided.

People knew who the registered manager was and felt confident in approaching them.

Staff spoke positively about how the service was managed.

A range of quality audit processes were in place to measure the overall quality of the service provided.

# Lulworth

**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 July 2016 and was unannounced.

The inspection was carried out by one 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. The expert-by-experience had experience of learning disability services and a range of care environments.

Prior to 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 reviewed the (PIR) and other information we held about the service. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care provided by staff to people. We spoke with four people living in the home, one relative and three visitors to the home. We met separately with the new manager and the registered manager and spoke with the area manager. In addition we spoke with one support worker and the manager of Blake during our inspection. After the visit we held telephone discussions with a further two support workers.

We spent time looking at records including three care records and three staff files including training records. We also looked at staff rotas, medication administration records (MAR), health and safety maintenance checks, compliments and complaints, accidents and incidents and other records relating to the management of the service.

The home was last inspected on the 24 October 2013 and there were no concerns.

Good

# Is the service safe?

## Our findings

People told us they felt safe in their home and our observations confirmed this. One person told us, "Yes I am safe here". Some people could not communicate verbally however looked at ease, relaxed and happy with the staff that were supporting them.

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us they would go to both managers with any concerns. One staff member said, "Straight away I would go to my manager". Another member of staff told us, "I would report something straight away". They also told us the training they were given kept people safe and said, "We know what we are doing and staff are trained and qualified". The home worked in accordance with their safeguarding adults at risk policy which provided information and guidance on keeping people safe.

Care records contained risk assessments. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We found risks were managed safely for people. They were specific to individual needs, updated and reviewed annually or sooner if required and captured any changes. For example one person had 17 risk assessments which had all been reviewed in March 2016. They gave direction to staff in how to support the person to blow dry their hair and how the person liked to receive their medicines. Another person had 15 risk assessments which had been reviewed in May 2016 and included areas such using the home's vehicle safely and the use of bed rails. Two people had risk assessments in place to enable staff to support them with anxiety related behaviours; these had been developed with the support of a psychologist. Staff told us that they were involved in developing risk assessments and how important they were in ensuring practices were safe. One member of staff said, "We read and sign risk assessments, they make you aware of the risk and helps you minimise the risk", and added, "We are always reading updates".

Accidents and incidents were reported appropriately and documents showed the action that had been taken afterwards by the staff team. This included events that related to the well-being of people. Records showed that the relevant professionals and relatives had been contacted. All accidents and incidents were discussed with the area manager to ensure actions had been taken to minimise the risk of future incidents.

We observed, and rotas confirmed, there was enough staff on duty to meet people's needs. People communicated their needs and staff responded to them without delay. Two separate staff teams supported Lulworth and Blake. Both buildings had 24 hour staff cover on duty. Lulworth had five staff on duty in the morning shift and four staff in the afternoon and evening with an additional staff member to work a 'mid-shift' to ensure people were able to access their preferred activities. Blake had three staff on duty each shift. A new member of staff said, "There is plenty of staff".

Medicines were managed safely. Only trained and competent staff were authorised to administer medicines

to people. One person told us, "I don't do my own because of my memory and I feel safer that they do it. I have it in the morning and at night time". People's medicines were held in a locked facility. They were mainly stored in blister packs which were labelled and corresponded with a clear recording system. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. We observed a support worker administering medicines. The Medication Administration Record (MAR) was completed and signed on behalf of each person by the support worker each time someone was supported to take their medicine. This meant that people received their medicines as prescribed. The support worker bent down next to each person and spoke discreetly to them about their medicines using a patient, calm and flexible approach. Guidance was also provided for staff when administering 'When required' (PRN) medicines. This included medicines for pain relief or skin conditions. A new staff member told us they had just started administering medicines to people and said, "The first time you do it has to be with a manager".

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting.

Good

# Is the service effective?

## Our findings

People received effective care from staff who had the skills and knowledge they needed to carry out their roles and responsibilities. People we spoke with were complimentary about the staff. They told us of the confidence they had in the abilities of staff and said they knew how to meet their needs. One person told us, "They're excellent at their job, wonderful". Another person said, "If there's anyone new (staff) they always come with someone and get introduced to us so we get to know them".

People received support from staff who had been taken through a thorough induction process and attended training with regular updates. The induction consisted of a combination of basic training, shadowing experienced staff, the reading of relevant care records and the homes policies and procedures. Staff records showed observations were carried out by managers to assess the competency of new and existing staff. A member of staff told us, "I shadowed until I was trained then I could go out with people and support them".

In addition to the service induction, the registered manager told us they had introduced the Care Certificate (Skills for Care) for new staff. The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. One new member of staff told us, "I am doing it, all new staff are".

The training schedule covered various topic areas including learning disabilities, epilepsy, autism and moving and handling. Records highlighted an experienced staff member required moving and handling refresher training and a new member of staff who was supporting people had yet to attend. We discussed this with both managers who explained a training date had been booked in August 2016. They also shared the new member of staff, after their induction, had been working at all times with other staff to ensure people were supported to move safely however agreed this had been an oversight and training should have been attended earlier. A manager from a home owned by the same provider was trained in facilitating moving and handling so training was booked immediately to ensure all staff were updated. This meant that the gap was addressed quickly to ensure people's care and safety was not impacted.

The managers also told us about specific workshops that had taken place with all staff who supported two people with a diagnosis of autism. The workshops had been facilitated by a psychologist the home had been working with; however this was not reflected in the training records we read. The managers told us they would revisit their training records to incorporate all learning opportunities staff had been provided. Staff told us there was enough training to meet the needs of the people they supported. One member of staff told us, "There is a lot of training, it's really good". As staff became more experienced they were provided with additional responsibilities such as shift leading and key working roles. A keyworker is a staff member who helps a person achieve their goals, helps create opportunities such as activities and may advocate on behalf of the person and their care plan. This practice seemed to develop staff's knowledge and understanding of people and the service as a whole.

Most staff had completed a National Vocational Qualification (NVQ) or were working towards various levels

of Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard. Those in supervisory roles achieved a level five HSCD to ensure they had the correct skills and knowledge to support other support staff.

Supervisions and appraisals were provided to the staff team by managers. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Supervision records confirmed staff were encouraged to demonstrate how they carried out their individual roles and responsibilities. One staff member said they received regular supervision and told us, "There is an open door policy you don't have to wait for a meeting". Staff meeting opportunities were provided monthly and they invited staff to share information about people and discuss any concerns they had. Another member of staff told us, "They are always there to listen to your ideas".

Consent to care and treatment was sought in line with legislation and guidance. 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, mental capacity assessments had been completed on behalf of all people and staff had received training on both topics. The registered manager told us, and care records confirmed that a standard authorisation DoLS application had been made for people who lacked capacity who lived at the home. So far, the home were waiting on the outcome to five DoLS applications and one DoLS had been approved; the process had included people's relatives and the appropriate health and social care professionals. Therefore people's rights had been protected in line with current legislation. A member of staff told us, "We must assume that everybody has capacity to make a decision even if I think it's not a very good decision".

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. We observed most people ate their lunch around the dining room table however one person said, "If you don't like what's for lunch you can have something different. I eat mine in the kitchen away from the crowds". Some people required 1:1 support from staff at mealtimes and the use of different aids to enable them to drink and eat with ease. We observed staff deliver this aspect of care sensitively and with confidence. For example people were asked if they wanted to wear clothes protectors rather than staff assuming they did. One person required a straw to drink with; another person used moulded cutlery and a plate guard to allow them to be as independent as possible. Staff were seen eating with people rather than separately which promoted a sense of a home rather than a task staff were just doing. People were also encouraged to be involved with mealtimes. One person was seen using a tea towel to 'dry up' after lunch and told us it was, "My job".

People's healthcare needs were managed effectively by the home. The support provided would vary depending on a person's needs. Where healthcare professionals were involved in people's lives, this care was documented in the care plan. For example, we noted that GP's, psychiatrists and psychologists were involved with some people's care. One person told us about a skin condition they had experienced and said, "They got the nurse to come and see me". A relative told us, "I have every confidence that medical

intervention would be sought". Healthcare action plans were completed annually with the support from a nurse. A healthcare action plan is a document that is drawn up about a person, it explains how they can keep healthy and the help they are able to get or are getting. This showed how the managers and staff were involved in supporting people with their healthcare appointments. Staff told us they would report to the managers if they had any concerns about a person's health. Staff were able to contact health professionals directly if there was a need. However staff also told us they would document any changes and report back to their managers to gain advice and guidance.

Good

# Is the service caring?

## Our findings

Positive, caring relationships had been developed between people and staff. Staff smiled with people and looked approachable; their interactions were warm and personal. Staff used people's preferred names during conversations and asked their permission before undertaking tasks. One person told us, "They (staff) are very nice, helpful and polite".

We observed people could move freely around the home assisted and supported by staff to where they wanted to be. This was consistently carried out by staff in a kind manner who offered support yet considered people also needed their own space. Staff enabled people to communicate and express themselves without 'jumping' in too early and taking over. This allowed people to take the lead and direct their own wishes. A visitor told us, "They show people so much respect; they talk to them like proper human beings and help them to say what they want". Staff were heard chatting to people about general matters such as the weather and what had been on television. Staff also covered topics pertinent to the individual such as people's favourite music, updates on people's relatives and what activity was planned. This meant staff had considered people's well-being when providing care.

People were supported to express their views and be as independent as possible. People we met were given key workers. A keyworker is a staff member who helps a person achieve their goals, helps create opportunities such as activities and may advocate on behalf of the person and their care plan. Staff became key workers once they had achieved their basic core training. People were involved in choosing their key worker. Key workers had a meeting with the individual on a monthly basis to ensure they were happy with their care and these meetings were recorded. For example one person discussed wanting to go to the pub and this was then supported. Keyworkers were able to talk through ideas, goals and aspirations for people further in their own supervision meetings, this ensured the necessary opportunities and action was taken on behalf of each person. In addition group monthly service user meetings were organised and provided people with an opportunity to discuss general issues on the service they received from the home. One person spoke about their involvement with the meetings and said, "Yes we have them so we can talk about what goes on and to make sure everyone is polite. They like us to let our feelings out and not be worried and keep it to ourselves". Another person told us how they knew about the meetings but chose not to attend and said, "I know I can go if I want to and I get to know what happens".

Staff told us how they encouraged people to do as much for themselves as was possible with regards to their own daily household chores. One staff member said, "If they want to make their own food they can. They are involved in cleaning their own bedrooms". Another staff member said, "One person likes unpacking the shopping, another service user goes to the home next door and collects the milk". This encouraged people's independence skills so they could exercise control over their daily routines.

Six people from both Lulworth and Blake, encouraged by the managers, had also formed the, 'Awesome interview team'. The team were involved with interviewing new staff and the group had been up and running for the past three months. Both managers were proud of how this had developed. During our inspection the team were involved in a meeting whereby the manager led a 'mock interview' with a member

of staff taking on the role of a person being interviewed. A mixture of verbal prompts or large printed questions were used to support people to pose their questions. One person who was non-verbal used a computer to put their question to the candidate. One person told us, "I feel that we discuss together who gets the job and we are all in it together". Another person told us what they looked for in a new staff member and said, "They have to be professional and respectful with us". Minutes of all meetings were kept by the home and reflected how people were actively involved in making decisions about their care, treatment and support.

We observed numerous occasions of how staff promoted and respected people's privacy and dignity whilst providing care and support. One person proudly showed us a 'values' board that had been completed with people living in the home. It contained pictorial and written references to how people wanted to be treated in relation to wishes, respect and dignity. As we read out loud some of the words displayed the person nodded and said clearly, "Yes" affirming they agreed and were part of what had been created. There was a strong culture in the home that people's bedrooms were their own domain and staff did not enter unless they were invited in. This meant people's privacy was promoted throughout both homes.

The 'Awesome interview team' and the 'values board' were aspects of the service that were potentially examples of outstanding practice. We recommend the provider take steps to develop and embed these aspect of the service over time to demonstrate the long-term impact and benefit to people using the service.

People were not only in control of how their bedrooms were styled they also were given a voice and a say in how communal areas looked. For example, the manager showed us a bathroom in Lulworth which had been decorated with a 'sea theme' and other animals such as ducks all chosen by people living in the home. All decisions surrounding the decoration were made at a service user meeting.

Good

# Is the service responsive?

## Our findings

Staff knew people well and responded to their needs in a personalised way. People's bedrooms were without exception decorated to meet what the person had chosen with regards to choice of colour schemes, décor and bedding. One person had fairly lights in their bedroom and was happy to show them to us. People told us they were able to choose how they spent their time and where and at what time they got up or went to bed. One person told us, "I like to get up at the crack of dawn and I have just one person (staff) to help me".

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. Care plans were reviewed regularly and included information provided at the point of assessment to present day needs. The home used varied formats including pictorial for people to support their understanding of the contents of their own care plan. The care plans provided staff with detailed guidance on how to manage people's physical and/or emotional needs, their goals and their aspirations. This included guidance on areas such as communication and behaviour needs, community activities and promoting independence. For example, one care plan read, '[named person] is a sociable, bright capable woman' it provided guidance on how upset they may become if they felt 'they were being ignored'. Another care plan gave direction to staff on how they should support a person to communicate with their relative in Australia using an IPad. A third care plan showed how a person had designed their own 'family tree' and named important people in their life. Positive Behaviour Support (PBS) plans were in place for people that may display behaviours that challenge. The plans had been developed with the support of a psychologist. They contained strategies of how staff should support people to reduce anxieties and manage behaviours displayed. Mangers told us how this approach had empowered people and enhanced their quality of life.

People's preferences and consent to their care was captured within care plans. On the front page of each care plan it stated written by and then provided the person's name. Keyworkers sat with people and went through them with each person. This meant people were involved in all aspects of their care planning and where that was not possible the involvement of family members was used. We asked one person about their involvement with their care plan and they said, "We have a keyworker review every month or two and we get together to talk about me. I do it then".

Daily records were completed about people by staff at the end of their shift. They included information on how a person presented during the day, what kind of mood they were in and any other health monitoring information. Changes to people's needs were highlighted through various methods including reviews and speaking directly to people their families.

We observed staff used appropriate communication methods and this was reflected in the care plans we read. One person was asked choices by using a hand tapping selection method; different members of staff used this style with the same person throughout our inspection with confidence. Other staff were seen using Makaton with people. Makaton is a commonly used type of sign language. The home considered people and their intimate relationships. They supported people to develop relationships with others that were

consensual and with the support of external health and social care professionals if required. People spoke openly about relationships past and present and how the home had supported them throughout each stage with patience and kindness.

The focus on activities was determined by how people wanted to spend their time throughout the week. Each person had an activity plan which had been decided with a keyworker or manager and included activities within the home such as baking, reading or floristry. In addition there was a focus on people accessing the community such as keep fit, swimming or college. On the day of our inspection we observed how people from Lulworth, Blake and a neighbouring home came together for a music session. This proved to be lively and enjoyed by all whether a person was playing an instrument or participated by dancing. We also saw a small group of people enjoyed a craft session. People spoke enthusiastically about their activities they were offered and able to attend. They also spoke of the day trips and holidays they had experienced and those they had planned with staff from the home. Two people were on an activity holiday at the time of our inspection and one person said, "They will tell us all about it when they get home". Another person said, "I'm going on holiday with [named staff member]" and pointed at their key worker. A relative told us how their family member attended a day centre three times a week and also said, "As well as all what's on offer here". Activity group newsletters which commenced in March 2016 captured people's views on how they felt about the activities they attended any actions were carried out by managers.

People and their relatives told us they knew who to go to with any concerns or complaints. The home had an accessible complaints policy in place and encouraged people and their relatives to approach staff with any concerns they had. The home had recently revised the policy into a pictorial format to ensure people who lived at the home understood its contents. One person said, "I would go straight to speak to [named key worker] or speak to the [named manger] or [named area manager]". Another person said, "I tell [named manager] anything". At the time of our inspection there were no outstanding complaints logged and most people were complimentary about the care provided. However one relative expressed frustration with how their family member's orthopedic boots had not been tied tightly enough by staff and felt it was a training issue. They told us they had already approached the manager with this. We fed back these comments to both managers who were keen to address the issue with staff and provide assurances to the relative.

Good

# Is the service well-led?

## Our findings

People liked living at Lulworth and Blake and told us it was a well-led home. One person said, "It's my home, it's like a family here". Another person told us, "I like it because it's a normal house, I'm very happy". A relative told us, "I can easily go and speak to staff or the managers here anytime; they are fine and most approachable". People enjoyed the relaxed and open culture the home offered. A visitor said, "It has a nice relaxed feel, there's never any unease or chaos or tension". Another visitor said, "The way people interact is marvellous".

Both managers demonstrated effective leadership and management during our inspection. They worked alongside other staff guiding them where necessary. They were keen to share why they felt the service they offered met people's needs. The managers introduced us to people who lived in the home and it was evident they knew people well. This approach was filtered down to care staff who had adopted this personalised approach. One person who had lived at the home had very recently passed away and it was evident that both managers and people who lived in the home were impacted by the loss. Managers were able to share the sensitive care they had provided to the person during their time at the home and in the hospital which captured their commitment to people they supported.

As the registered manager provided support for both Lulworth, Blake and a neighbouring sister service the staff teams came together for training sessions. This meant staff had access to additional learning opportunities and an extended support network. Staff complimented the managers and the support they were offered. One member of staff said, "They come on the floor to help with personal care. We have great management". Another staff member told us, "We are a great team. I like the way its run, how it's led there is lots of communication with support workers, we are all involved".

In addition to service user meetings the registered manager sought the views of people, relatives and staff annually using survey's to ascertain how they viewed the care the home provided. The pictorial design given to people who lived at the home enabled them to understand the contents more easily. We read a selection completed by people which all contained positive views. For example, one survey completed by a person in March 2016 had responded to the question, 'What does the service do well?' the response was, 'Good staff and nice food'. Another survey asked a person in January 2016, 'What could the service improve?' the response was that the person wanted a summer holiday planned'. We checked to see if the holiday had been organised and it had. Relative surveys completed in November 2015 included entries which read, 'Staff are very friendly and communicative', and 'Integrates service users into the community safely but with sensitivity'.

Some people had also been involved with service user led compliance audits on the sister home next door. One person told us he no longer takes part however was able to tell us of the input he provided. Both managers encouraged people's participation in this process and provided us with the document they had devised for people to use. It posed questions about staff approach and other areas such as the quality of the activity and food offered on the day they visited. Both managers told us they wanted service user input to continue as it was both valuable and meaningful and helped develop services further.

A range of informal and formal robust audit processes were in place to measure the quality of the care delivered. The quality assurance file showed how detailed compliance audits had been completed in areas such as care plans, environmental checks and supervisions by the area manager. When items were highlighted they were given an action date of when it needed to be completed by. In addition the managers completed a daily walk round the service to ensure equipment and the environment was safe for both people and staff. Managers had also been involved in looking at trends in people's behaviours that may challenge which in turn had removed anxieties for some people.

Both managers were passionate about the care and support they provided to people. The registered manager said, "We (staff) are the outsiders it's their home". They added I am proud of the staff team. I am proud of the service". When asked for their biggest achievements in the home they provided a list titled 'Accomplishments we're proud of'. The list focused on examples of how they had supported people to reach their life goals. It included how they had been able to work alongside various health and social care professionals to provide stability and remove obstacles some people had when they first moved into the home. It also referenced how they had supported one person to get married and how they were supporting them to complete a marathon race for charity. They told us, "Service users come first".