Shine Partnerships Ltd

Hazelwood House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place over one day on 4 February 2016 and was unannounced. At our last inspection on 17 December 2013 we found that the provider met all standards that we inspected.

Hazelwood House provides supported living to four adults with mental health and complex needs. People have assured shorthold tenancy agreements and their own flats within the service.

The service had a registered manager. 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.

People told us that they felt safe within the service and well supported by staff. We saw positive and friendly interactions between staff and people. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Medicines were administered safely and on time. Staff had completed training in medicines and administration. People were supported to become independent with their medicines in a structured and safe way. People understood what their medicines were and why they had been prescribed.

Risk assessments were written in collaboration with people. People were able to tell us why they had risk assessments and how risk assessments helped them identify triggers in them becoming unwell. The provider showed excellent inter-agency working and regularly shared risk assessments with mental health care professionals.

Staff received regular supervision and appraisal that helped them identify areas for learning and development. Supervisions and appraisals were used as an opportunity for staff to improve care practices.

The service focused on the recovery model of care which puts people's individual recovery at the heart of care provided. People were positive that the home was a stepping stone to enable them to have a full and active life.

The service ensured that people had individual tailored activities that reflected their interests and goals. People attended college or had part time employment. People told us that the provider created a 'family atmosphere' within the home. Trips abroad and within the UK were organised by the provider and people

using the service. People were encouraged to have a normal, fulfilling life and look towards the future.

Staff understood the principles of the Mental capacity Act (MCA) 2005 and were aware of how this impacted on the people they worked with both in theory and in practice.

There was excellent communication and joined up working between the home and mental health services. Health care professionals spoke highly of the management of the service and the care the service provided.

There were regular reviews of people's mental health. Staff knew how to refer people for both physical and mental health issues. People were involved in planning their own healthcare needs.

People were supported to have enough to eat and drink. Staff encouraged healthy eating and helped people plan meals and recipes.

People were encouraged to have as much control and input into their care as possible. The service focused on people's individual recovery. People told us that they wrote their own care plans and were supported by staff. Care plans were personalised to the individual and monitored through regular key working. People were positive about the care that they received from staff and felt that they were treated as individuals.

We saw that the provider encouraged innovation. A new on-line computer system had been installed that allowed staff to work on tablets, wherever they were within the home. Staff were able to spend more time with people and complete work confidentially.

The provider encouraged learning and development. Training was updated regularly and monitored by the manager. Staff had regular supervision and annual appraisals that helped identify training needs and improve the quality of care. Staff felt the provider listened and responded to new ideas and issues.

The registered manager was accessible and spent time with people. We saw that there was an open culture within the service and this was reflected by the staff. Staff felt safe and comfortable raising concerns with the manager and felt that they would be listened to.

There was a clear management structure in place. People who used the service and staff were aware of the lines of accountability. This allowed for excellent communication and an atmosphere where staff and people felt able to appropriately challenge each other and discuss ideas that led to improvements in the quality of care.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care. There was a complaints procedure as well as incident and accident reporting. Surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

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. Staff were able to tell us how to recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against. Risk assessments were shared with healthcare professionals.

People were supported to have their medicines safely. Staff were knowledgeable about the medicines they were giving. People understood their medicines and were encouraged to be involved.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals were made when necessary to ensure their wellbeing.

People were supported to have enough to eat and drink to ensure their dietary needs were met.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care.

Staff treated people with dignity and were patient and kind when interacting with people.

Is the service responsive?

Good

The service was responsive. People wrote their own care plans in collaboration with staff. People knew what their goals were and how they could be achieved.

Staff were knowledgeable about individual support needs, their interests, and preferences and actively supported people.

People were encouraged to have full and active lives, be part of the community and maintain relationships with family, friends and people that mattered to them.

People were encouraged to lead full and active lives including, education, employment, holidays and social activities.

A system for complaints was in place and people were encouraged to complain. People were comfortable raising issues and felt listened to.

Is the service well-led?

Good

The service was well led. There was a positive and open culture that encouraged best practice and this was encouraged by management.

Staff were able to be innovative and discuss ideas that improved the quality of care for people.

Health care professionals spoke highly of the management and culture of the home.

The provider supported staff education and training to ensure knowledge and best practice was implemented in the care provided.

Hazelwood House

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 4 February 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service sent to the CQC. We looked at four people's care records and risk assessments, six staff files, four people's medicines charts and other paperwork that the service held.

We spoke with three people who used the service, five staff and one relative. Following the inspection we spoke with two mental health care professionals that worked with the provider. We observed interactions between staff and people who used the service.

Good

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said "I like it here. It's a very nice place. I feel safe." Another person said "I'm always safe here." A relative told us, "Yes, I don't have any concerns about [relatives] safety there." Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. There were notices in communal areas telling them who to contact if they needed to report abuse. People told us, and we saw, that safeguarding was regularly discussed in resident's meetings and people were encouraged to report any concerns if they needed to. The service's safeguarding policy was available and accessible to staff. Staff training records showed that staff had completed training in safeguarding.

Staff understood what whistleblowing was and how to report concerns if necessary. How to report concerns and contact details were clearly displayed on the office notice board. Staff told us that the provider and registered manager actively encouraged people to raise concerns around safeguarding and that protecting people was at the heart of the services values.

Risk assessments were person centred and written in collaboration the individual. People had full input into how risks were managed and mitigated against. Risk assessments were detailed and gave guidance for staff on how to support people in the least restrictive way. All risk assessments were updated every six months or immediately when risk factors changed. We saw that one risk assessment had been updated to reflect a 'major life event' for a person.

Risk assessments included assessment of mental health relapse indicators. All risks were assigned a status of high, medium or low risk depending based on the person's history. People that we spoke with were aware of their risk assessments. One person told us, "Yes, I know. Staff went through it [the risk assessment] with me."

The registered manager told us that it was important for people to understand, where possible, why they have a risk assessment. It also helped people recognise specific behaviours that could mean that their mental health was deteriorating.

Risk assessments were shared with mental health professionals and any changes reported to them immediately. A mental healthcare professional that worked with the service told us, "They [the service] monitor the level of risk [regarding people] and communicate with us at all times."

There were sufficient staff to allow person centred care. We saw that there was one staff member in the mornings and one in the afternoon with one sleeping-in at night. A sleep-in shift is where the staff member is on the premises and available in case of emergency but not awake. The manager told us that if a higher level of support was needed for people, they increased staffing levels to meet people's needs. We observed an increase in staffing levels on the day of our inspection to support a person who was becoming unwell.

The service followed safe recruitment practices. Staff files which showed pre-employment checks such as

two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

We saw records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue, if there had been any investigation, the outcome and any learning from the accident or incident. The registered manager told us that any accidents or incidents were discussed at team meetings to provide an opportunity to learn. Staff meeting records showed that incident and accidents were discussed at team meetings.

The service had a clear medicine administration policy which staff had access to. The home focuses on support and recovery for people and people are encouraged, when they are ready, to move on to self-medicating.

Staff were able to explain different types of medicines given to people living with mental health conditions and what side effects could occur. Staff were aware of how to recognise side effects of different medicines and knew how to refer people if they needed to. Staff were able to explain the appropriate health care professionals that they would refer people to such as, GP's, community psychiatric nurses and psychiatrists.

People's medicines were recorded on medicines administration record (MAR) sheets. People who had their medicines administered by staff or who were on stage one of self-medicating process used the blister pack system provided by the local pharmacy. A blister pack provides people's medication in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one month supply. We looked at MAR's for November and December 2015 and January 2016 and found that there were no omissions in recording. Medicines were given on time.

There was an up to date detailed self-medicating policy. The policy recognised that each person was an individual and that people's progress would be led by the person and assessed by staff on a regular basis. The policy noted, 'It is important that all service users are given the opportunity to progress, with the view to becoming fully independent and self-medicating all of the time'. There were four stages to the self-medicating process. At each stage, a detailed risk assessment was completed. Before a person moved on to the next stage, a further risk assessment was completed and signed off by the registered manager. Risk assessments were also discussed and shared with people's mental health care managers. The policy stated, 'Each client is different and some may progress faster than others, any progression will be decided with the client in consultation with their MDT (multi-disciplinary team) and the staff team at Shine'. Records showed what stage of self-medicating people were currently on. Each person had a medicines cabinet in their room for when they moved onto self-medicating.

One person had injections as part of their medicine regime, provided by a local clinic. We saw records that ensured that the person had received their medicine and when their next one was due.

There were records for as needed medicines. As needed medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious. There was detailed guidance for staff for when to offer as needed medicines to people and staff were able to tell us in what circumstances they would offer PRN medicines. Staff told us that before as needed medicines were offered they tried other techniques such as talking to people. One staff member said, "If someone is prescribed Zopiclone (a sleeping tablet) we would encourage them to have a hot drink and relax before bedtime. We want to help decrease the chemical sedatives where possible." The home had a culture of encouraging people to be aware of how they were feeling and work though this rather than using as needed

medicines as a first line solution.

We observed staff administering medicines. The person requested their medicines and was invited into the office. This person was at the first stage of self-medicating. Staff went through a checklist with the person including, their name, to ensure it was the correct medicine, what the medicine was, that the person had a glass of water and how they were going to go through the process. The person was given the blister pack and staff observed them removing the tablets and taking them. Staff then signed the MAR sheet. There was excellent communication and support throughout this process.

The service promoted people's independence by ensuring that they were fully involved in their medicines. Staff worked closely with other healthcare professionals for the best interest of people. People told us, and we saw, that progress with medicines was discussed in key working meetings. There was a file in the communal areas with general information on medicines that people could access at any time. Staff told us that they felt it was important for people to be aware of what medicine they were taking as it allowed people to feel more in control of their own health and wellbeing. People said that they felt empowered by how the staff supported them with their medicines.

One person told us, "I self-medicate, I know what I'm taking and why I'm taking it. I re-order from the GP and get it from the pharmacist and bring it back. Once a week I refill my dosset box with staff. I take my morning and evening [medicines] and shout staff that I've taken it. Each week they randomly do spot checks to make sure I'm taking it." Records confirmed that spot checks for people self-medicating were carried out.

Medicines were stored in a locked filing cabinet. This had been audited by the local pharmacist and the provider was informed that this was acceptable. However, the provider said that they would be ordering a medicines cabinet. We contacted the registered manager 72 hours after the inspection who said that an appropriate medicines cabinet had been ordered.

All staff members on shift were provided with a panic alarm. The panic alarms were linked to a call centre. If activated someone from the call centre was able to contact the staff member and talk to them through a microphone in the alarm hand set. The alarms were also linked to a global positioning satellite (GPS) which allowed staff to take the alarms in to the community with them when accompanying people. Staff told us that the alarms were also motion activated. If the alarm detected that someone had fallen they would be immediately contacted by the call centre. One staff member told us how they had accidentally fallen over and had been contacted within seconds to ask if they were ok. If activated the call centre are able to respond immediately and send emergency services if required. This provided staff with assurance that they were safe while carrying out their role both within the home and community.

The service had up to date maintenance checks for gas, electricity, electrical installation and fire equipment. Fire alarms were tested and recorded weekly and there were monthly fire drills. A recent fire risk assessment was in place. Staff were aware of how to report any maintenance issues. We looked at maintenance records and saw that issues were dealt with in a timely manner and signed to say that they had been completed.

The service was clean and tidy on the day of our inspection. Staff and people told us that they cleaned daily. People were responsible for cleaning their bedrooms and there was a rota for cleaning communal areas. This was included in people's individual care plans.

Good

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us and records confirmed that they were supported through regular supervisions. Staff told us that they received supervision every month. One staff member said, "In supervision we look at what we can help staff develop. We encourage people's passions and help them champion those passions. "We were given an example of staff that had identified that they were interested in activities planning for people. This person has been given the responsibility to plan and develop activities for people. If staff felt that they needed supervision outside of the booked monthly meetings, they were able to request additional support. The registered manager said that requested supervisions were always provided.

Staff told us that appraisals helped pin point areas for [self] development. A staff member said that supervision and appraisal was, "About developing staff strengths and individual abilities." The provider recognised that each staff member had strengths that could be developed which helped increased staff knowledge and the quality of care. Another staff member told us that appraisals provided, "feedback and the opportunity to identify training needs. Plans to move forward with better understanding of what I want to achieve over the next year."

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures, medication training and specific mental health awareness. Training records showed that staff received regular training that supported them in their role.

Regular training was provided for staff of all levels. The registered manager told us that many of the staff were also training as psychologists, occupational therapists and nurses. Rotas were compiled in a way that supported staff education whilst ensuring that people living at the home received regular committed support. The provider told us that staff learning was vital and improved knowledge and working practices. The registered manager is currently undertaking a Masters (MA) in Forensic Mental Health. This has been provided and supported by the provider. Staff are given time off study. Time off is assessed by the manager to ensure that the service remains able to provide a high level of quality care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Staff had received training in to understand circumstances where people could be deprived of their liberty. One staff member told us, "We must assume everyone has capacity. Someone may not have capacity in one area but fine in others. It [capacity] needs to be assessed if you suspect someone may not have capacity. May need to involve independent mental capacity advocate."

All people living at the service had been assessed as having capacity and they were not being deprived of their liberty.

Staff were able to tell us the procedure if a person were unable to make decisions regarding their care. Staff understood what best interests meetings were and under what circumstances they would be necessary. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests.

People living at the service were independent. They purchased ingredients and cooked their own meals. Where people needed support to cook and plan meals, they were supported by staff. Two people told us that staff encouraged them to eat healthily. We saw key working records that showed healthy eating and meal planning was regularly discussed with people. One person had requested that staff support them to cook more regularly. This had been included in the person's care plan. One person said, "I cook a minimum of twice a week. We discuss food in key working sessions. They [the staff] help me with my diabetes."

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by healthcare professionals was included in peoples care plans. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. We saw that people had regular, recorded meeting with community mental health teams. One person said, "I feel as if I have control over my healthcare."

There were regular Care programme Approach (CPA) meetings with multi-disciplinary community mental health teams. CPA meetings provide a way in which services are assessed, planned, co-ordinated and reviewed for people living with mental health needs. A healthcare provider said, "The manager, and sometimes the owner, will come to [people's] CPA's. He's [the owner] involved. It's not like he meets the patients once and doesn't bother. He really knows them and gets involved." People's risk assessments and care plans were updated to reflect changes when issues were identified in CPA meetings. Records confirmed this.

Good

Is the service caring?

Our findings

People were treated with respect and their views about their care were understood and acted on by staff. One person said, "To be honest, I think it's really good." Another person told us, "I'm happy here, the staff support me." One relative said, "I think the care is really very good. The standard is quite high. They care and they help." The atmosphere within the home on the day inspection was calm and relaxed. We saw friendly, pleasant interactions between staff and people.

People told us that staff knew them well. Care records had a section with people's personal histories, likes and dislikes. Staff were able to tell us, in detail what each person liked and enjoyed. This was reflected in the interactions that we observed between staff and people.

Each person living at the service had a key worker. A key worker is someone who is responsible for an individual and makes sure that their care needs are met and reviewed. People we spoke with were positive about the care and support they received from their key worker. One person told us, "My key worker is very, very good. He's considerate, he cares about me and how I'm progressing." Another person said, "No complaints, brilliant. My keyworkers always ready to go the extra mile. Always puts residents first." People told us that they had key working every three weeks but were able to request extra key working sessions if they needed to. Records showed that requests for extra key working sessions had been responded to by staff.

Staff treated people calmly and with respect when they became anxious or showed behaviour that challenged. Staff told us that they knew people well and understood each person's individual needs when they became distressed. We observed staff responding to a person who was distressed and becoming unwell. Staff allowed the person space and supported them when they approached staff. We observed that staff met and discussed the best way to support the person and agreed an action plan.

People's care plans noted if they needed prompting with their personal care and how the person liked to be prompted.

We asked staff how they would work with gay, lesbian or bisexual people. Staff told us that this would not make any difference to how the person was treated. One staff member said, "No differently than I would with anyone else. Unless there was something specific they asked us to do around that. It's a personal approach." Another staff member said, "I don't see the problem?"

Staff understood how to provide care and support in a way that maintained a culture of dignity and respect. One staff member said, "It's things like, I wouldn't walk into people's flats. If they say no, we respect that." During the inspection, staff asked people if they were willing to show us their flats. Staff waited for people to consent before continuing. When we arrived people were getting ready for their day. Staff asked people if they were willing to talk to us before going out. Staff told us that they always, "Asked people if it was ok to do things as if it was me, I'd want to be asked." There was a culture within the service of 'treating others how you would want to be treated'. One person said, "They always treat me with dignity."

We saw that people's care files noted if they had a faith. Staff told us that because people were independent they attended places of worship alone or with family members.

Records showed resident meetings were held weekly. People told us that they could talk about anything they wanted to. This meant that people were given the opportunity to express their views and contribute to how the service was run.

People and staff told us that friends and family can visit whenever they want. One relative told us "Yes, I can visit whenever I want to. The staff are really helpful"

The service did not complete form around people's wishes for end of life care. We discussed this with the registered manager. This issue has been discussed by the management team and with people who use the service. People who used the service did not think that filling out final wishes forms helped them look towards their recovery.

Good

Is the service responsive?

Our findings

Care plans showed that staff responded to people's needs as identified. Care plans were reviewed regularly and updated as changes occurred. Staff knew about individual needs and had read the care plans. People told us that staff knew them well understood them as individuals. One person said, "Staff really get me."

People's care plans were personalised. People were supported to write their own recovery and support care plans that reflected how they wanted to receive their care and support. One staff member told us that the recovery and support plans were "Led by the client and look at what they [people] want to achieve. It doesn't need to be grand, something specific that can be measured." The registered manager said that the recovery and support plans were, "For the clients. The CPA care plans are written for the professionals and are very long. The recovery and support plans are guided by the service users." One person told us, "I wrote most my own care plan. We [staff and person] check my progress during key working. It's about what I want to achieve." Another person said, "Yes, I have input into my care plan, always."

Care plans detailed what the person wanted to achieve over the next three months. There was a section that detailed how the person themselves was going to achieve their goals and also how staff could support them to do so. The care plan also detailed how issues could be addressed if the person went off track with their care plan. One person said, "Staff will remind me if I go off track. We talk about my goals and change things if they are not working." We saw that care plans were flexible and responsive to the individual.

All people that we spoke with were able to tell us what their care plans contained and how they were supported to achieve their identified goals. People were positive about the standard of care that they received and said that they were comfortable with discussing their experience of care within the service and were actively encouraged to do so.

Care records showed that people and their relatives had been involved in the initial assessments and on-going reviews of people's needs. As part of the initial assessment, people were able to spend time at the service on a trial basis so that staff could become familiar with their needs. This included day visits and overnight visits. This also allowed people to become familiar with the staff and the service. There was a detailed, step by step, referral procedure for both healthcare professionals and people. This was given to people when they were referred and explained what they could expect from the process and what their rights were. The process could take a couple of months to ensure that people are comfortable and ready to move into the community. The registered manager explained what the purpose of a longer term assessment was, "Gradual visits to the accommodation to build rapport with staff and assess on-going suitability of the placement prior to discharge [from hospital]."

Health care professionals said that throughout the assessment process, staff had communicated well and ensured that the person understood and been able to express how things were going. If there were any concerns during the referral process, these were discussed with the mental health teams. One mental health professional said, "It's not about money for them [the provider], they really do care and wanted the best for [person]. If something is not going well, they will talk to me about it." One person told us, "I accepted it here

[the home], I liked it. First I came and had a look round, then did some overnight stays. Then I moved in."

The provider had created an induction pack for people who were new to the home. The pack informed people of what they could expect from the staff whilst living at the home, such as key working, residents meetings and being treated with respect. There were also communal house rules for people. People said that they had found the induction packs useful. The registered manager had also placed a copy in the communal areas for people to read at any time.

People were encouraged to have a full and active life and follow their interests and aspirations. One person had been supported to carry out a part time job and was also looking for work experience in the field that they wanted to go into. Another person was attending college with a view to gaining employment. A mental health care professional told us, "They have a lot of activities tailored to [person]. They [the home] have supported him to go to college three days a week. He has a better quality of life because of the staff encouragement." One person was a passionate football supporter and attended football games with staff. Another had joined a gym and was being supported to attend.

People maintained personal relationships with family and friends. Care plans reflected the importance of maintaining these relationships for people. People told us that they regularly saw family and friends.

The registered manger told us that each year, the provider arranged trips to European destinations. People were consulted on where they wanted to go and encouraged to save money to help pay for their trip. There have been trips to Basel in Switzerland, Barcelona in Spain and Euro Disney in Paris. The provider also arranged trips within the United Kingdom. People who did not want to travel abroad often attend these trips. People and staff told us that these trips were important. Where people had been very unwell, the trips allowed people to realise that they could recover from their illness with help and support and lead a normal life. A staff member said that the trips were, "An opportunity to observe them [people] and to assess how they function in different settings. A lot can be gained from taking people out of their normal environment. It also enables people to have a normal life, to breakdown some of the barriers for people who may have been in hospital for a long time."

The provider had installed an internet and television provider throughout the house. People had individual hubs in their flats and were able to access the internet as they wished. This supported people in completing work for college and work placements. It also allowed people to follow their interests and hobbies.

The service had a complaints procedure that was available for staff and people to read. Complaints were investigated and recorded in detail, including the outcome. We saw that people were regularly reminded of the complaints procedure during residents meetings and key work sessions. There was a complaints box in the hallway of the home. One person said, "There's a slip and a complaints box. I've never needed to use it. If I have a problem I'll just discuss it in the monthly meeting." Another person said, "I am able to speak up if I am not happy about anything, they always listen to me."

One person told us about an incident where they did not feel as though they should complain and did not feel confident to do so. Staff were aware that there was a change in the person's behaviour and encouraged them to talk about what was bothering them. The person was encouraged to make a complaint and supported throughout the process and felt that, "they [the management] took it seriously." The person was kept informed throughout the process and supported by the staff. The registered manager told us that, "listening and responding to people in the right way" was vital to ensure that people felt supported.

Good

Is the service well-led?

Our findings

There was a positive open culture within the service. The manager knew people well and both people and staff were encouraged to voice their views and opinions.

Management had a consistent clear vision and strong values which was reflected when talking to staff and healthcare professionals. Staff were aware of the values of the home and had been trained in this during induction.

The registered manager had been with the company for six years having started as a support worker. She told us, 'I like the company. I have the freedom to change things and improve the quality of care. The provider allows me the freedom to be independent and try new things, see if it works. Very supportive." The provider allowed the manager to be innovative and supported ideas that improved the quality of care for people.

The service had recently installed a computer system that contained people's information. This included all care plans, risk assessments, personal histories, daily records and medicines information. The registered manager told us that this was an initiative she had introduced with the support of the provider. Staff said that the system was easy to use and update. The home had a mobile computer tablet that staff were able to carry with them and access the computer system from wherever they were in the service. This meant that staff were not constrained to working in the office. The registered manager told us that the home planned to be a paperless environment and that all staff files and information would be included on the system over the next few months.

Staff and healthcare providers spoke highly of the leadership at Hazelwood House. A healthcare provider that worked with the service said, "We recommend them [the service] for our patients. We find them very hands on. They take on board and understand everything we say. Compared to other places in the community where we have to do rigorous monitoring for complex clients, we provide a little less with Shine as the manager and staff are so competent." Another healthcare provider said, "I am pleased with the care. The manager is excellent."

The registered manager carried out monthly audits of medicines, staff files, health and safety and quality of care. Staff completed weekly medicines audits that were cross checked each month. There were monthly audits of client files including, care plans and risk assessments. The registered manager checked that people's information was up to date and that any changes in people's care had been updated. Where necessary, changes were made to improve the quality of care and the overall service. The registered manager told us that if issues were found with regards to people's information the keyworkers would be notified and a time frame put in place to address any problems. This would then be re-audited by the registered manager.

There was a resident's survey completed in July 2015. The registered manager told us that the feedback was a learning opportunity to find out people's views and change things if something was identified. We saw that

people had requested more activities, the provider had responded by appointing an activities coordinator that worked across the homes run by Shine. Results of the survey were discussed in a resident's meeting and people were given the opportunity to feedback.

Records showed that staff meetings were held monthly. Agendas for staff meetings were circulated by email so that staff could add things that they wanted to discuss. We saw that staff were kept up to date about company developments, such as the provider expanding the business. Legislation and good practice were regularly discussed. At the end of meetings an action plan was developed. This was revisited at the next meeting to ensure that any actions identified had been completed. Staff were encouraged by the registered manager to raise and discuss ides that could improve the quality of care within the home. The registered manager told us that they sustained and improved quality of care by discussing ideas and sharing them as a team. If something was identified it was followed up and progress monitored.

All policies and procedures held by the service were up to date and included date for review. The provider updated policies as and when necessary according to legislation changes and reviewing care practices within the service.

Monitoring of maintenance issues was recorded. The registered manager told us that recording of maintenance would be transferred to the computer system over the next two months. The maintenance person for the home would be able to access this section of the online records to update. The computer system allowed the registered manager to set access to certain information held for each staff member. The maintenance person would not be able to access confidential service user information.