Leonard Cheshire Disability

St Bridget's - Care Home Physical 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

The inspection took place on 19 and 26 July 2016 and was unannounced.

Following an inspection in August 2015, we asked the provider to take action in response to breaches of regulation. The service was not safe in all areas. Risk assessments were in place but people may not have been protected from harm as their care records did not always contain the most up-to-date guidance on how to mitigate risks. Medicines were not always managed properly or safely and there was unclear guidance for staff on the use of barrier creams. There were not enough staff at all times of day to meet people's needs in a timely way. The service was not consistently responsive. People could not be certain to receive personalised care that met their needs because records detailing their needs were inconsistent. The service was not well-led. The quality assurance system was not effective at monitoring and improving the quality of the services provided. As a result, the provider sent us an action plan that outlined the actions that had been taken in order to achieve compliance. At this visit, we found that action had been taken and these requirements had been met.

St Bridget's - Care Home Physical Disabilities is run by the provider Leonard Cheshire Disability. It is a care home for people needing personal care and accommodation that provides care for up to 38 people who have a range of physical disabilities, some of whom have an associated learning disability. At the time of our visit there were 30 people living at the home. The home's brochure states that they [Leonard Cheshire Disability], 'Have been providing support to people for over 60 years and we now work at over 200 sites in the UK.' The website states that, 'We support disabled people to have the freedom to live their lives the way they choose.'

In the Provider Information Return (PIR), the registered manager stated that, 'In addition to their bedrooms people have access to communal areas including lounges, activities room, a small kitchen, and various outside spaces. All accommodation and facilities for people who live at St. Bridget's is on the ground floor and accessible for people who use a wheelchair. All bathrooms have been refurbished in the last year and have fully automatic baths and ceiling track hoists.'

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from risks to their health and wellbeing. Up to date plans were in place to manage risks, without unduly restricting people's independence. Risk assessments were reviewed regularly so information was updated for staff to follow.

People said they felt safe at the service and knew who they would speak to if they had concerns. The service followed the West Sussex safeguarding procedure, which was available to staff. Staff knew what their

responsibilities were in reporting any suspicion of abuse.

People were treated with respect and their privacy was promoted. Staff were caring and responsive to the needs of the people they supported. Staff sought people's consent before working with them and encouraged and supported their involvement.

People's health and well-being was assessed and measures put in place to ensure people's needs were met in an individualised way. Medicines were administered safely.

People were supported to eat and drink enough to maintain their health. People at risk of choking had been assessed by a Speech and Language Therapist (SaLT). The assessments gave clear details of people's eating, drinking and swallowing needs. This included the different textures of food and thicknesses of fluids that people needed to manage their individual risk of choking. Additional snacks and drink were available; however the onus was on people to ask for them. They were not routinely offered to people.

There was an open and friendly culture combined with a dedication to providing the best possible care to people. Staff at all levels were approachable, knowledgeable, professional and keen to talk about their work. The atmosphere in the home was happy and calm. Every person we spoke to, without exception was extremely complimentary about the caring nature of the registered manager.

Staff received training to enable them to do their jobs safely and to a good standard. They felt the support received helped them to do their jobs well.

There were enough staff on duty to support people with their assessed care needs. The registered manager considered people's support needs when completing the staffing rota and staffing levels were calculated appropriately. The registered manager followed safe recruitment procedures to ensure that staff working with people were suitable for their roles.

People benefited from receiving a service from staff who worked well together as a team. The registered manager and care supervisor took an obvious pride in their work and were looking for ways to improve the service. Staff were confident they could take any concerns to the management and these would be taken seriously. People were aware of how to raise a concern and were confident appropriate action would be taken.

The home had a programme of activities, however people complained of being, "Bored". We recommend that the registered manager review the activities provision at the home to ensure that it meets people's needs.

The premises and gardens were well maintained. All maintenance and servicing checks were carried out, keeping people safe. People were able to feedback their views about the home.

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

Risks to people had been assessed and appropriate measures were in place to manage the risk, without unduly restricting people's independence.

There were sufficient numbers of staff to meet people's care needs in a timely way.

Staff understood their responsibilities to protect people from abuse.

People told us they felt safe living at the home.

Medicines were administered safely.

Is the service effective?

Good

The service was effective.

Staff received the training, support and supervision they needed to be able to provide safe and effective care.

People were asked for their consent to care and treatment. Where they were unable to make a decision the principles of the Mental Capacity Act were followed.

The registered manager had ensured that relevant applications to the statutory authority in relation to Deprivation of Liberty Safeguards had been submitted.

People told us that food at the home was good. Special diets were catered for and choking risks had been assessed.

People health needs were assessed and monitored and appropriate referrals were made to other professionals, where necessary.

Is the service caring?

Good

The service was caring.

Staff were caring and quick to help and support people.

People were encouraged to be as independent as possible, relearn skills and make their own decisions. They were treated with kindness and respect; their dignity and privacy were upheld.

There was a friendly and relaxed atmosphere in the service with good conversation and rapport between staff and people.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People were not always occupied and stimulated. People complained of being bored.

People's individual needs were assessed, planned and responded to by staff who understood them.

People were encouraged to raise any concerns. Complaints were investigated and action taken to make improvements.

Is the service well-led?

Good

The service was well-led.

There were quality assurance systems in place to effectively monitor and improve the quality and safety of the service.

There was an open culture in the service, focussing on the people who used the service. Staff felt comfortable to raise concerns if necessary.

Staff were aware of their roles and responsibilities. The registered manager provided clear leadership which was backed up by the care supervisor.

St Bridget's - Care Home Physical 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.

The inspection took place on 19 and 26 July 2016 and was unannounced.

One inspector and a Speech and Language Therapist (SaLT) undertook this inspection.

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 also reviewed previous inspection reports and notifications received from the service before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We looked at care records for five people, medication administration records (MAR), a number of policies and procedures, eight staff files, staff training, induction and supervision records, staff rotas, complaints records, accident and incident records, audits and minutes of meetings.

During our inspection, we observed care; spoke with 13 people who lived at the home, six relatives the registered manager and 15 staff on duty, including different grades of care staff, kitchen staff and ancillary staff. We also spoke with a visiting dietician.

Good

Is the service safe?

Our findings

People looked at ease with the staff that were caring for them. All people we spoke with told us that they liked the home. We were told that, "There is a good standard of care". People told us that they liked the staff. Comments included, "The staff are wonderful, they all do their best".

People benefited from a safe service where staff understood their safeguarding responsibilities. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding adults at risk. Staff were able to clearly describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. They said that they would raise any concerns with a senior member of staff. The registered manager was clear about when to report concerns. He was able to explain the processes to be followed to inform the local authority and the CQC. The registered manager also made sure staff understood their responsibilities in this area. The service followed the West Sussex policy on safeguarding; this was available to all staff as guidance for dealing with any such concerns.

At our last inspection we found a breach of regulation associated with the assessment and management of risk and made a requirement for the service to improve. At this inspection we found that improvements had been made. The manager completed an assessment before a person moved to the service. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified these had been assessed and actions were in place to mitigate them. For example people's risk of falling from bed had been assessed and bed rails were in situ if necessary. We saw that hoists and wheelchairs were used to help people move around safely. Staff provided support in a way which minimised risk for people. Following two serious safeguarding incidents in the past year, the service has taken action to address risks related with swallowing and choking. People who required support with eating were provided with well-paced support. Staff were appropriately positioned and at the correct eye level according to people's needs. People had good positioning and support to enable them to enjoy their food and be safe. Some people had adapted crockery with plate guards in order to assist their independence.
People's Care plans contained detailed and clear information regarding people's risk of choking and how to manage the risks. People at risk of choking had been assessed by a Speech and Language Therapist (SaLT). The assessments gave clear details of people's eating, drinking and swallowing needs. This included the different textures of food and thicknesses of fluids that people needed to manage their individual risk of choking. We saw that one person needed drinks thickened to level 2. What this entailed was clearly documented in the person's care plan. The catering supervisor told us that she was involved in the care planning alongside the registered manager and the care staff. This meant that she was actively aware of people's individual needs and special dietary requirements. The catering supervisor discussed the difference between solid, semi-solid, fork-mashed and pureed foods. We were told, and records confirmed, that staff had received training from the SaLT. This training included the differences in food textures. The Catering Supervisor told us that the training was completed with the care staff. She said that she feels very much part of the team and not an, "Outsider". "It is a team effort and the care staff are brilliant. It's not like them and us".

We saw that there were copies of people's SaLT assessments and risk assessments in the dining room and in the kitchen. This included photographs with a clear description to demonstrate to staff what the different textures of food and drinks looked like. This meant that staff had all the information they needed regarding people's risk of choking during mealtimes.

The care plans contained information about people's malnutrition risk assessments. People's weight was recorded to monitor whether people maintained a healthy weight. People were weighed monthly and their weights monitored to note any unusual gains or losses so that their diet could be tailored. People with particular dietary requirements had access to and support from a dietician. Where people were at risk of dehydration staff maintained fluid charts. We noted that the fluid intake for some people had been raised for information during staff handover. This demonstrated that staff were monitoring people and taking action to ensure that their needs were met. □

The premises and garden were well maintained and well presented. Environmental risk assessments had been completed, which assessed the overall safety of the home. All maintenance and servicing checks were carried out, keeping people safe.

At our last inspection we recommended that the staff deployment needed reviewing to ensure that people's needs were met in a timely way. At this inspection we found that improvements had been made. There were enough staff to meet people's care needs. The registered manager considered people's support needs when completing the staffing rota and staffing levels were calculated appropriately. We observed that staff supported people in a relaxed manner and spent time with them. During our visit we saw that staff were available and responded to people in a timely way. Staff told us they were happy with the staffing levels. Relatives we spoke with told us they would, "Benefit from information regarding which staff are on duty and who is in charge." We were told that, "It is sometimes difficult to know who is who because staff don't wear name badges and there are no pictures of them anywhere. It's great that they don't wear uniforms, but it can be confusing." This was discussed with the Registered Manager, who told us that he would look into ways to address this.

Staffing rotas for the past four weeks demonstrated that the staffing was sufficient to meet the needs of people using the service. We saw that people were supported to attend appointments, for example with their GP. There were ten care staff during in the morning, seven in the afternoon and three at night. The staff numbers had been recently increased so that the team leader was not required to provide care. The manager told us that this would give them greater oversight of the shift and enable more accurate handover information.

Safe recruitment practices were followed before new staff were employed to work with people. We were told that recruitment checks were carried out by the provider's HR department, but the decision whether to recruit was made by the manager. We were told, and records confirmed, that people living at the home took part in the interviewing of potential new staff. Checks were made to ensure staff were of good character and suitable for their role. Staff were recruited in line with safe practice and we saw eight staff files that confirmed this. For example, employment histories had been checked, references obtained and appropriate checks undertaken to ensure that potential staff were safe to work with adults at risk. Staff records showed that, before new members of staff started work at the service, criminal records checks were made with the Disclosure and Barring Service.

At our last inspection we found a breach of regulation related to the safe management of medicines. We made a requirement for the service to improve. At this inspection we found that improvements had been made in this area. Peoples' medicines were managed and administered safely. We observed medicines

being given. Staff carried out appropriate checks to make sure the right person received the right medicines and dosage at the right time. We saw that care was taken to ensure that people received medicines at the correct times. Some people were prescribed medicines to be taken 'as required' (PRN). There were clear guidelines for staff regarding administration of PRN medicines. We saw that these were given in accordance with people's needs. We saw that there were guidelines for staff regarding the administration of prescribed topical creams. These included when and where prescribed creams should be applied. People were asked if they needed assistance to take medicine, and any help was given in a discreet and caring way. Staff only signed the Medication Administration Record (MAR) sheets once they saw that people had taken their medicines. Medicines were recorded on receipt and we saw the records of disposal. Medicines we checked corresponded to the records which showed that the medicines had been given as prescribed.

People's medicines were stored safely and kept securely. We observed that all medicines were kept secure. We saw that a lockable fridge was available to store medicines that required lower storage temperatures. The fridge temperature was monitored to ensure that medicines were stored at the correct temperature to ensure their effectiveness.

Staff told us of the training they had received in medicines handling which included observation of practice to ensure their competence. All the staff we spoke to regarding the administration of medicines told us that they felt confident and competent and our observations confirmed this.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet people's needs. They had confidence in their skills and knowledge. A person told us, "They do their utmost". Most relatives told us that they were satisfied with the care given. People appeared well cared during our visit.

One relative told us that staff's, "Attention to detail could improve. People sometimes have dirty mouths, food on belts." This was discussed with the care supervisor who was aware of improvements that were needed. Specific improvements required were discussed with staff during supervisions.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's care needs. Staff received regular training in topics including, swallowing and choking, epilepsy, people focus and safeguarding. Records were kept detailing what training individual staff members had received and when they were due for this to be repeated. The registered manager had analysed training requirements for individual staff and we saw that training had been booked in advance to meet the identified needs. The staff training records confirmed that the training was up to date. A person told us that staff received a, "High amount of manual handling training". Staff were positive about the training opportunities available. People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles.

New staff were supported to understand their role through a period of induction. The registered manager told us that new staff's progress was reviewed monthly by the registered manager during their three month probation and their contract of employment was confirmed when they had achieved a satisfactory level. New staff continued on to undertake the Care Certificate when their in-house induction was completed. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers nationally are expected to achieve.

People were supported by staff who had regular supervisions (one to one meetings) with their line manager. All staff we spoke with told us they felt supported. They said there was opportunity to discuss any issues they may have, any observations and ways in which staff practice could be improved. The care supervisor told us that she was responsible for the team leader's supervisions and that the role of the team leader was being increased. Comments on the supervision records we saw included, 'This is my first supervision I have had where I actually feel valued and listened to. I feel a lot more positive about working here since [Name] has become care supervisor.'

Staff told us there was sufficient time within the working day to speak with the registered manager or senior staff on duty. During our visit we saw good communication between all grades of staff. Staff felt that they were inducted, trained and supervised effectively to perform their duties.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood when an application should be made and how to submit one. The registered manager told us that an application had been made for a person who did not have the capacity to consent to bedrails, to prevent him from falling out of bed, although they were compliant with their use.

Staff had a good working knowledge on DoLS and mental capacity. Staff had received appropriate training for MCA and DoLS. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was an assessment to show otherwise. People were able to give consent regarding their day to day life, for example what they had to eat and drink. There were actions to support decision-making with guidance for staff on maximising the decisions people can make for themselves.

During our visit we observed that staff involved people in decisions and respected their choices. We saw that staff had an understanding about consent and put this into practice by taking time to establish what people's wishes were. We observed staff seeking people's agreement before supporting them and then waiting for a response before acting. Staff made sure that people had understood the questions asked of them. They repeated questions if necessary in order to be satisfied the person understood the choice available. A person told us, "I get lots of freedom, I can choose what I do."

People generally had enough to eat and drink throughout the day and night. We saw that people were able to ask for drinks throughout the day. Relatives we spoke to raised concerns regarding the length of time between the evening meal and breakfast and the lack of availability of drinks and snacks. Drinks and snack were no longer available for people to help themselves to due to the number of people at risk of choking and the number of people who required food and drinks at a specific consistency. The onus was on people to ask the staff if they required something. One relative told us that, "[Name] could have an evening snack if he asked for it. But he doesn't ask. He's not that type. Most of the people here won't ask." Another relative suggested, "When it's hot, they could go round with a trolley of drinks. If people see drinks then they will want one."

We observed the lunchtime meal experience. Lunch was taken in varying places within the home according to people's preferences. We saw one person went to the servery, got his food on a tray and went to another area to eat. Another person had lunch in their room with their visitor.

People were engaged in conversation. The mealtime was an inclusive experience. We observed many positive interactions between people and staff. We saw that when a member of staff walked past a dining table and a person stopped them to ask something, they took their time to respond and did not ignore this communication opportunity. Staff appeared caring and took pleasure in spending time with people. There was a lively yet relaxed atmosphere; people were not rushed during their meal. We saw that staff asked people if they had finished prior to removing their plates.
We saw the catering staff talking to people in the dining room, to check if they had liked the meal.

We have covered the details of managing risk associated with eating, drinking and malnutrition in the SAFE domain of this report.

Staff we spoke with knew people's preferences and told us that all people were able to indicate their likes and dislikes. People told us that they liked the food. One said, "They try their best to please as many people as they can," and, "All the food is fresh".

People had access to health care relevant to their conditions. The home had a part time occupational therapist (OT) and physiotherapist, together with assistants who were employed full time. This meant that these services were available to people every week day. In addition to this, people had access to GPs and dieticians. We saw that people were supported to attend healthcare appointments or visits to the home could be arranged.

We spoke with the physiotherapist, who told us that they carried out a joint assessment with the occupational therapist when people were admitted to the home. The results of their assessments were then shared with the care staff to ensure consistency of care. Any specific instructions regarding people's care was recorded in the communication book and shared during staff handover. Additional training was also arranged for staff if required. For example, training in how to put on splints and people's correct positioning in bed or their chair. Photographs were taken for people's care plans so that staff could refer to them and had a visual check. We saw that the home had a dedicated room for physiotherapy. We were told that the room had been recently rearranged so that its set up was similar to a gym. This included having a wall mounted television and music. The physiotherapist told us that the aim was to make it a more sociable experience. She told us that, "There is a real sense of bringing the outside world in. It's lots of fun working here. There are professional boundaries combined with a sense of fun and friendliness. You really get to know people well, which is especially important with people with communication difficulties."

Staff knew people well and referrals for regular health care were recorded in people's care records. People had detailed information recorded about them which provided hospital staff with important information about their health if they were admitted to hospital.

People had a health action plan which described the support they needed to stay healthy. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Good

Is the service caring?

Our findings

People received care and support from staff who knew them well. The relationships between staff and people receiving support demonstrated dignity and respect. People we spoke with thought they were well cared for. They told us they liked the staff. People described them as, "Very nice" and told us, "I feel like I matter". Relatives told us that, "The staff are lovely", "Caring" and, "There is a solid group of well trained, faithful, hardworking staff".

Throughout our visit staff interacted with people in a warm and friendly manner. The staff team focused their attention on providing support to people. We observed people smiling and spending time with staff who gave them time and attention. Staff knew people's individual abilities and preferences, which assisted staff to give person centred care. Staff were aware of people's individual communication needs and methods of communication. People who were unable to verbally communicate had assistive technology in place to support them. These devices gave people a 'voice'. Staff were confident and competent in the use of assistive technology and were able to have two way communication with people. One person's care plan said, 'I manage my environment and surroundings using supportive technology: I have a voice activated control unit for telephone, TV and alarm and voice recognition software for my laptop.' The home had an adapted computer room for people to use. The adaptations included different height desks, larger keyboards, track balls and joysticks.

When communicating with people, staff got down to their level and gave eye contact. They spent time listening to them and responding to their questions. They explained what they were doing and offered reassurance when anyone appeared anxious. Staff made sure people were comfortable and had everything they needed before moving away. The home was spacious and allowed people to spend time on their own if they wished. We saw that several people were moving around during our visit.

Each person had a keyworker who was allocated based upon preferences and common interests. The keyworker provided a focal point for people amongst the larger staff group and ensured they received person-centred care. They took a social interest in the people they were allocated to and were involved in support plan development with people.

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Each file contained information about the person's likes, dislikes and people important to them. We saw that each file contained a life story, which, where possible had been written or dictated by people.

People's care plans described the level of support they required and gave clear guidelines to staff. The care plans were person centred; they contained details of people's backgrounds, social history and people important to them. The care plans included details regarding people's individual likes and dislikes. Staff we spoke with said that they found the care plans useful. They were aware of people's personal preferences. People told us they received the care that they wanted and were happy with the care received. Staff knew what people could do for themselves and areas where support was needed. Staff knew, in detail, each

person's individual needs, traits and personalities. They were able to talk about these without referring to people's care records. Staff said that they believed that all staff were caring and were able to meet the needs of people.

The overall impression was of a warm, friendly and safe environment where people were happy.

Requires Improvement

Is the service responsive?

Our findings

People were supported to maintain their independence and access the community. Some people were able to access the community independently. For example, we saw that a person had been to the local shops to get some scampi as she, "Didn't fancy what was for lunch". She told us that she particularly fancied a takeaway.

We saw that some people were engaged and occupied during our visit; there was a calm atmosphere within the home. Some of the people were interacting with each other and chatting with some of the staff. Staff and people told us that they liked each other's company. All relatives we spoke with told us that they were involved in their relatives' care. Relatives told us that they thought that the level of social interaction and activities provided could be improved. A relative had commented, "Sometimes people look like they are bored. They don't have anything to do. They look like they are lost." Another relative said, "Boredom remains a problem." All the people we spoke with indicated that they would like, "More to do" and, "More activities". All the people we spoke with told us that they got, "Bored" and, "Fed up".

People had a range of activities they could be involved in. These included: cookery club, gardening club, art club, quizzes, board games and a Saturday club. People were able to choose which activities they took part in. We were told that people could, "Visit the beach, the village, local shops, garden centres, restaurants, pubs and attend local church services," and that some people were also able to, "Attend clubs outside of the service such as a gun club, knitting club, swimming and horse riding". Some people and relatives told us that the activities on offer were not of interest to them and made several suggestions of activities they would enjoy, for example swimming, a reading group and acting groups. A relative told us, "[Name of person] gets bored. A lot of the activity sessions are more practical, which is difficult for [Name] with their disabilities. [Name] wanders around a lot which is disappointing." We were told that trips out were organised, including occasional theatre trips and regular Wednesday outings during summer. People told us that they enjoyed the trips. One person told us, "We don't get out enough." We recommend that the registered manager review the activities provision at the home to ensure that it meets people's needs and expressed preferences in response to this feedback.

At our last inspection we found a breach of regulation related to the completeness of contemporaneous records about people's care needs. We made a requirement for the service to improve. At this inspection we found that improvements had been made. Staff maintained a daily record for each person that recorded the support they had received. Staff did a verbal handover each shift to ensure that all staff were aware of people's needs and had knowledge of their well-being. This ensured that any changes were communicated so people received care to meet their needs.
People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and professionals involved in their care. Information from the assessment had informed the plan of care. This ensured that the staff were able to meet people's needs. In the Provider Information Return (PIR), the registered manager stated that, 'Any potential Customers are assessed prior to moving into a service. Once people move into our services we create a personal plan and health plan with the staff team that holistically considers people's needs and aspirations. This includes the individual's needs

and choices and consent to care and treatment.'

People's care needs were kept under review and any changes or increase in dependence was noted in the daily records and added to the care plans. This meant people received consistent and co-ordinated care that changed along with their needs.

People's needs were reviewed regularly and as required. Where necessary health and social care professionals were involved. For example, we saw that a person with a low nutritional intake had had a PEG (percutaneous endoscopic gastrostomy) feeding tube and was being seen regularly by the dietician. During our visit we spoke with a visiting dietician. We were told that, "Staff are receptive to training. They are keen and interested in nutrition. The keyworkers are very interested in their patients, they have a good relationship with them."

The service had a complaints policy and a complaints log was in place for receiving and handling concerns. The complaints policy was available in a pictorial format. Complaints were logged on a central system which allowed senior managers to access and monitor. People told us that were confident that any issues raised would be addressed by the registered manager. A relative told us, "Any concerns are dealt with. [Manager's Name] comes up with sensible solutions." Six complaints had been received in the last year, all of which had been appropriately investigated and resolved.

Good

Is the service well-led?

Our findings

The home had a positive culture that was person-centred, open, inclusive and empowering. People appeared at ease with staff and staff told us they enjoyed working at the service.

At our last inspection we found a breach of regulation associated with a lack of effective systems in place to monitor the service that people received and ensure that it was consistently of a good standard. At this inspection we found that improvements had been made. Quality assurance systems monitored the quality of service being delivered and the running of the home, for example cleaning and health and safety audits. The findings of the audits were collated and an action plan was completed. The action plan included dates for completion. The action plan was updated as actions were completed and this was then monitored by the registered manager to ensure necessary improvements were completed. We found that the concerns raised at the last inspection had been addressed and improvements made.

Accident and Incident forms were completed. The information was logged on a central system. An investigation was carried out locally, but senior health and safety staff were able to view the records. These were then analysed for trends and patterns. All identified areas for improvement were clearly documented and followed up to ensure they were completed.

Regular safety checks were carried out including those for the fire alarms, fire extinguishers, water temperatures, portable electric appliances and equipment suitability. Where there was corporate learning from accidents, health and safety alerts were issued to the services within the group. Staff told us that any faults in equipment were recorded in the maintenance book and were rectified promptly. The provider had achieved a level five rating at their last Food Standards Agency check.

The registered manager told us that there was a new care supervisor in post since our last inspection. The registered manager had delegated tasks associated with the delivery of care to the care supervisor. This allowed the manager more time to spend on managerial tasks. We were told that she was, "Dynamic" and "Keen to improve [the service]". Relatives told us that there had been a noticeable improvement in the service since the care supervisor was in post. A relative told us, "The place is completely different since [care supervisor]. The care supervisor and manager make a great team. I have lots of confidence in the manager. In the last six months there have been some dramatic changes. The manager has worked really hard. There are still little things. People need their glasses cleaned and that sort of thing. You won't find a better manager than [name]."

Staff and people using the service said the registered manager was open and approachable and they would go to him if they had any queries or concerns. Staff felt confident to raise any concerns. Staff felt supported by the registered manager and told us that the home was well led. A staff member told us that the registered manager is, "Really hands on. He understands the problems. His door is open. He goes well above the call of duty, he never says no. The place is so much better, much more positive. He's really settled things down".

A relative told us that the service, "Is well led and the manager has a good relationship with them" Another

relative told us that the manager and the care supervisor, "Make an outstanding team. They really work well together".

We were told, and records confirmed, that staff meetings took place regularly. Staff used this as an opportunity to discuss the care provided and to communicate any changes. Staff were aware of what their roles and responsibilities were and the roles and responsibilities of others in the organisation. They felt confident to raise any concerns with a senior member of staff or the registered manager.

People were empowered to contribute to improve the service. People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Annual surveys were carried out with people and their relatives.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure the provider responded appropriately to keep people safe.

In the Provider Information Return (PIR), the registered manager stated that, 'Service quality is audited by the national quality improvement team; services are audited thematically or a full service audit is undertaken. Health and Safety audits are carried out by the health and safety team and in addition services may be audited as part of contract compliance. Following a visit or audit services produce an action plan with clear timescales for actions. Internally audits are completed by the senior team. These include monthly medication audits.'