Orwell Housing Association Limited

William Wood House

Inspection report

School Street
Sudbury
Suffolk
CO10 2AW

Tel: 01787311940
Website: www.orwell-housing.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

William Wood House provides care and support to people living in specialist 'extra care' housing. Extra care housing consists of single household accommodation in a shared site or building. The accommodation is the occupant's own home and is provided under a separate agreement. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. The service does not provide nursing care. At the time of our inspection there were 30 people using the service. They lived in separate flats with shared areas including gardens and a large lounge and dining room.

The inspection took place on 12 and 14 September 2017 and was unannounced.

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

The manager was passionate and committed in their role. They worked well with their new area manager and they had put a detailed action plan in place which was improving the quality of support being provided, and addressing concerns in an open and effective manner. They prioritised risk well and continued to address poor practice despite the on-going staffing challenges.

The manager had focused on improving the safe administration of medicines over the last six months. Staff had been retrained, medicine care plans revised and other systems improved. However, during our inspection we became aware of a medicine error during which staff had not responded effectively and in a timely manner when a person's medicines had run out. This example highlighted areas where the improvements put in place by the manager had not yet become firmly established.

The manager was also facing concerns around staffing levels. Where no staff were available, they had prioritised direct care to ensure people's needs were met and were often providing care themselves. At our inspection we were told a new additional team leader role had been created and there was on-going recruitment to ensure the manager had a full staff team and could focus on running the service. Despite the pressure on staffing levels, recruitment processes remained robust. There was some reliance on agency staff, however systems to improve the induction for these staff had been revised to help them understand better the aims of the service and people's needs.

Risk was well assessed and measures put in place to support people to stay safe. Staff knew what to do if they had concerns regarding people's safety. People were supported to communicate their preferences and to remain as independent as possible. Staff had developed positive relationships with people and treated them with dignity.

Staff were experienced and confident in their role. They were well trained and supported, though the recent

staffing pressures had led to a dip in morale. The needs of people at the service were becoming more complex, especially in the area of dementia. The manager was working well with professionals to support staff to develop skills and to adapt the support people received to ensure it continued to meet their changed needs.

Staff enabled people to access outside health and social care agencies where necessary and worked well with other professionals to promote people's wellbeing. People choose what they ate and drank in line with their preferences.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005. While most people at the service had capacity to make choices about their care support, the manager knew of the need to consider any legal requirements where people's capacity was becoming more variable. Staff respected people's right to make their own decisions about their life and support.

Detailed assessments of need were carried out and personalised care plans were in place which provided staff with guidance on peoples' needs. Staff followed a schedule of visits as agreed with people and their families, where appropriate. People were supported to develop person-centred routines in line with their preferences. They also benefited from the 24/7 presence of staff if they needed one-off or urgent support.

There were varying opportunities to provide feedback about the service and to raise concerns and complaints. The manager and provider were open with people where there were issues at the service and consulted them on any proposals for change.

There were robust systems in place to check the quality of the service and make improvements, where necessary. These usually worked well, however recent staffing issues meant they were not functioning as well as usual during the period of our inspection. However, this was addressed immediately after the inspection by the creation of a new additional team leader role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The improvements which had been introduced to ensure the safe administration of medicine had not yet been fully implemented.

The provider was resolving the concerns about staffing levels and availability. Staff were recruited and safely.

The service knew how to support people to minimise risk.

Is the service effective?

Good

The service was effective.

Staff had varied opportunities to develop their skills, which included specialist guidance to ensure staff had knowledge about people's individual needs.

People's right to make their own choices about their life choices and the support they received was promoted by the manager.

People could choose how and where they wanted to eat. Staff supported them to maintain their wellbeing and access health and social care professionals.

Is the service caring?

Good

The service was caring.

Staff developed positive relationships with people.

Care plans had been revised to promote choice and support.

Staff treated people with respect and dignity.

Is the service responsive?

Good

The service was responsive.

Support was personalised and based on people's individual

preferences.

There was good communication with people when their needs changed.

There were a number of opportunities to raise concerns and complaints were investigated thoroughly.

Is the service well-led?

Good

The service was well led.

The service was led by a manager who was passionate about implementing changes which improved the service.

The manager was visible and approachable.

Robust formal systems and procedures to check the quality of the service were in place.

Care Quality Commission

William Wood 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 checked 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 was a comprehensive inspection.

The inspection took place 12 and 14 September 2017 and was unannounced. The inspection team consisted of two inspectors and two experts 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 experts by experiences had personal experience of caring for older people. One carried out phone calls to people who used the service and their families. The other expert by experience visited the service with us, carrying out most of their interviews in the communal area.

We reviewed the information we had available about the service including notifications sent to us by the provider. This is information about important events which the provider is required to send us by law. We also looked at concerns we had received, particularly in relation to staffing and errors in the administration of medicines. 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. Before the inspection we sent questionnaires to gather views about the service. We received a response from 10 people, one relative, five staff and two professionals. This information helped us to plan what areas to focus our attention on for the inspection.

We focused on speaking with people who lived at the service and observing how people were cared for. In total we spoke with or met with 11 people and nine family members. We met with four care staff, the registered manager and the team leader. We also had contact with three health and social care professionals to find out their views about the service.

We looked at three people's care records and examined information about the management of the service such as recruitment, staff support and training records and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

During our inspection we became aware of a recent incident in which a person went without pain relief over a four day period. Staff had ordered the medicines but not acted in a timely and coordinated manner when they were not delivered on time. Ordering medicines for this person was the responsibility of the service. When the manager became aware of this incident it was taken seriously and escalated to the area manager for a full investigation.

We noted that training and systems to minimise risk during the administration of medicines had been improved in the last year, following a medicine incident involving a different person in 2016. The recent medicine error highlighted that care staff and senior staff had not communicated and worked effectively to keep the person
safe. This demonstrated that although the service had learnt from previous errors, there was still room for improvement to ensure people's safety. We were however assured by the pro-active response by the manager and provider, such as the increase in staffing levels and the extensive number of new measures to improve the administration of medicines.

All staff had received refreshed training in medicines administration in the last six months. We looked at minutes of recent staff meetings and saw that these were used to regularly provide detailed advice and to highlight the seriousness of any errors. The provider had introduced a new competency observation for staff so that the manager could check they had the necessary skills to support people safely. For example, the manager carried out assessments of staff competence and where a member of staff was not fully competent the manager had provided additional guidance and re-assessment. There were detailed monthly audits to ensure there were no errors in the administration of medicine. Although the audits had not picked up the incident we had looked into, we noted the checks had picked up where other mistakes had taken place and concerns had been dealt with pro-actively.

Medicines were stored in people's flats and so permanent arrangements for storing medicines were not needed. Medicine care plans had all been revised since 2016 and stated clearly who was responsible for ordering and disposing of medicines. On the day of our inspection the medicines had arrived and were being sorted by a senior member of staff. The new team leader showed us the current system and described their plans for re-organising the medicines room, to minimise the risk of mistakes being made. The manager advised us that the medicines room had been re-organised immediately after our inspection.

During our visit we observed a member of staff administering medicine. They demonstrated good skills and knew how to respond and record if a person refused their medicines. Apart from the specific incidents referred to in this report, the people we spoke with were positive about the support they received with their medicines. One person said, "Staff see to all that, including repeat prescriptions. They come round and bring the meds in the morning and afternoon. It means I do not worry and live my life".

We had feedback that staffing levels were variable. One relative said, "I think the staffing levels are not good.

They do use agency staff quite a lot to cover." Families were overwhelmingly unhappy with the use of agency staff who they did not feel provided the same level of care as existing staff. A professional told us the use of agency staff led to some inconsistency as they did not have a full understanding of the needs of the people at the service.

Some family members and one person told us people were not always responded to promptly, mainly at weekends. Other people were more positive about staff responses. A person told us, "Occasionally on Sundays you have to wait a bit for someone to come, but generally they are very good. I have no qualms about the staff, they make sure I am OK and comfortable." A new call system had been fitted in the service which made it easier to analyse how quickly calls were responded to. We asked to see the call bell response times for a particular person over a weekend before our inspection. We noted that over a three day period they had rung the call bell ten times and all the calls had been responded to within a minute. When we arrived at the service outside of office hours there was a brief delay as all staff were supporting people to get up. However, during our two visits we were not aware of any unanswered call bells, though staff were busy and clearly juggling their time effectively.

We discussed the staffing levels with the manager, who acknowledged there had been a recent high turnover of staff and recruitment was a challenge. The manager was able to assure us they ensured there was always enough staff on duty to meet people's needs and keep them safe. Where there were staffing shortages these were met by agency staff or by the manager and team leader providing care. We looked at rotas and saw that these had been well organised with built in gaps so that staff could pick up unexpected care needs. The manager acknowledged the recent staffing issues meant that staff rotas had to be rearranged, which meant that the timing of some visits had changed, which had led to some dissatisfaction amongst people and staff.

A health and social care professional told us, "The manager had been firm and tough, this has caused some rumblings (amongst staff)." The manager acknowledged they were focussing on improving the effectiveness and skills of the team. This had resulted in a period of instability in staffing levels and the change in culture had not suited all existing staff, leading to some staff departing. However, there was evidence of active recruitment and positive impact as new staff joined the team. The manager told us this would in time reduce the need for use of agency staff.

There were particular concerns amongst family and staff about night time staffing. One family member told us, "There is sometimes only one on at night. This is a worry about (person)'s safety." Another family member said, "I think my relative is safe during the day but maybe not at night because sometimes there is only one staff on duty. They worry in case they will not be able to get hold of anyone in an emergency."

Although families felt they would prefer a second member of staff overnight, we did not find significant impact in relation to the safety of the people. For example, a person had fallen and the member of staff had called emergency services in a timely manner. The member of staff had not sat with the person once they had made them comfortable, as they had been called to support another person; however there was no indication the person was unsafe.

We discussed the role of the night time staff and were told by the manager they were responsible for emergency visits and security. Where people needed two people to assist them to bed, this took place before 10pm, while there were still two members of care staff on duty. If a person needed care tasks to be provided routinely after 10pm, this would have to be set up as a specific care package and another member of staff would come in especially to carry out that task. This was not currently in place for any of the people at the service.

We discussed with the manager the overnight care arrangements for each person with complex needs. We found that the staffing had been considered in detail. For example, where a person's needs had deteriorated the manager had made a referral to an occupational therapist who had introduced a new piece of equipment which meant the person could still be supported with their personal care needs by one member of staff. We found this was a constantly evolving situation and it was clear that if people's needs continued to become more complex within the service then additional arrangements for staff would be needed overnight.

There were on call arrangements where a team leader or the manager could be contacted out of office hours by staff on duty. We found in our discussions with staff, team leaders and the manager that there was some lack of clarity over the role of the on-call and their availability to attend the service in person, especially when contacted by night staff. The area manager acknowledged this system needed review and told us were hoping to employ a peripatetic night leader; who would be responsible for the on-call support across a number of the provider's services.

Despite these concerns, when we spoke to people using the service they overwhelmingly told us they felt safe with the staff who supported them. People told us, "I feel perfectly safe. I am well looked after. I would speak to the manager if I was worried about anything;" and, "I am very happy with them, yes." Many family members were equally positive. They told us, "[Person] is very safe with them. They are very happy and would tell me if not."

There was an effective recruitment process in place for the safe employment of staff. Staff confirmed they did not start working until the necessary checks such as satisfactory Disclosure and Barring Service (DBS) checks had been obtained. People who used the service met with staff during the selection process and a new member of staff fed back that this had been a very positive experience. A person told us, "The manager brings them round to see us in the lounge, it's good to see them and have a chance to comment."

Staff knew how to work with other professionals to keep people safe. We saw in a team meeting there had been a discussion on the outcome of various safeguarding alerts which had been raised. Staff had been reminded who to contact to raise concerns and when we spoke to them they knew the correct actions to take if needed. Staff had received training in safeguarding and a professional from the local authority had visited to provide guidance to staff on safeguarding awareness.

There were good quality risk assessments which considered people's individual circumstances. For example the safety of each person in the kitchen had been considered and support tailored round their needs. One person no longer used their cooker but did use their grill with staff support and this was clearly outlined in their care plan. Risks were rated, according to the level of concern about people's safety, and this was signed off by the manager. For instance, a person had been assessed as "amber" in relation to falls, and appropriate measures had been taken to support them safely. Where another person presented a specific risk, there was a protocol attached to the risk assessment with clear personalised instructions for staff outlining when and what they should do in specific circumstances to support the person to keep safe.

Good

Is the service effective?

Our findings

Despite the concerns which had been raised about skills in medicine administration, people were supported by staff who were competent and well trained. Feedback from families was mostly positive, relatives said, "They are all marvellous. I have nothing but praise for them" and "They give (person) excellent support."

The manager made use of a variety of resources to ensure staff had the required skills to meet people's needs. When a specific piece of equipment arrived the manager had arranged for an occupational therapist to provide training to staff to ensure they knew how to use it. Where people needed support with moving and transferring, staff had clear guidance which had been developed in consultation with the appropriate professionals. This guidance was signed off by the manager and stated how many staff and what equipment was needed to support a person. Care plans included the exact description of any equipment so that staff could provide support in line with people's needs.

Staff had been given advice sheets on working with people with dementia, which demonstrated the manager knew this was an increasing need amongst the people they supported. The guidance was practical, for example, it advised staff to break activities into small steps. The manager had arranged for a dementia specialist to visit to provide more advice to staff. Care plans promoted an enabling approach to working with people who had dementia. Staff were advised that despite a person's dementia they continued to have the ability to come and go as they wished from their flat.

Training was a mixture of e-learning and face to face training which included Health and Safety, First Aid and Manual Handling. There was a detailed training plan which highlighted any gaps in staff attending training. Before supporting people independently new staff shadowed more experienced staff. The manager carried out regular observations to assess staff competence and we noted these had continued, though their frequency had reduced due to the staffing pressure. We observed staff were confident in their role. One member of staff noted that a person's catheter strap was not sitting comfortably on their leg and felt able to tell us how they were going to resolve this.

Although we had some concerns raised about the use of agency staffing, we noted that they all received an induction to the service, which included advice on care plans and on-call arrangements. Where agency staff were not meeting the required standard, there was open communication with the agency to ensure they were re-trained and if concerns remained, they did not return to the service.

There were good measures in place to provide supervision and team meetings and though these had not taken place with the usual frequency over the summer, it was clear the systems usually worked very well. Annual reviews were detailed and reflected on staff skills and what they had learnt through their training. Staff largely told us they felt well supported, though there was general recognition that the current staffing issues were affecting morale.

We checked whether the service was working within the principles of The Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the

mental capacity to do so for themselves. 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 manager told us there were no restrictions at the service, as people were free to come and go from their own flats as they wished. There were no locks on the front door of the communal entrance and where a person was using bed rails, they had full capacity and so were not being unlawfully restricted. We noted as people's needs were becoming more complex, staff were providing increased levels of supervision. For example, they monitored the safety of a person with dementia who was at risk of wandering, though this did not involve continual supervision. There were discussions about future options for increased monitoring, such as sensors on people's doors to alert staff when they were leaving their flat. The manager agreed to continue reviewing the support provided, in line with current legislation, so that the necessary measures could be taken if any restrictions on people's freedom were introduced.

People had signed to consent to care being provided when they first moved into the property. Although care plans were reviewed, in the isolated situations where people were starting to present with variable capacity, there was scope for a more formal review and recording of their capacity to consent to care. Throughout the care plans there was excellent guidance to staff about the importance of offering choice and we saw this in our observations of interactions between staff and people, for example, when staff offered a person a choice of when to have their evening meal.

An outside caterer provided a hot meal at lunchtime which could be served in people's rooms or in the communal dining area. The quality of the food provided was not part of our inspection but we noted there were flexible arrangements for people who needed support with having a balanced and healthy diet. Care plans provided clear advice about people's dietary needs. They outlined whether a person wanted support to eat in the dining room but also highlighted where they might chose instead to eat in their rooms, if they felt like a change. A relative told us, "[Person] eats in the dining room or sometimes has meals warmed in their room." Support was personalised and flexible. Where a person had memory loss, staff were told to remind them what meal had been prepared, while staff supported another person by putting snacks out where they could reach them. At a tenant meeting the manager had reminded everyone to drink plenty of water while the weather was hot to prevent dehydrated.

People were supported to maintain their health and wellbeing and to access professionals as needed. The manager described good relationships with local agencies, such as GP surgeries. Relatives told us, "Staff will contact the doctor straight away if [Person] is not well" and "They will take [Person] for routine blood tests and things like that." We spoke with a community nurse who was visiting and they told us, "We have had problems with other homes but this is not one of them." We saw that as people's needs became more complex as a result of dementia, the appropriate agencies had become involved which had improved the outcomes for people. For example, as a result of the involvement of a dementia specialist team, staff had increased their support to a person and had received more detailed guidance to enable them to support the person effectively.

Good

Is the service caring?

Our findings

A person told us, "The carers here are the salt of the earth, always cheery in the mornings. I don't know what I would do without them." Relatives said, "Our family member has fallen on their feet there. We have nothing but praise for the staff" and "The carers are lovely and supportive. Nothing seems to be too much trouble for them. [Person] is much better, much more relaxed and less fearful than before they came here. They were still calling me up at odd times for reassurance for a while, but that's now stopped because they feel safe and cared for here." Where there were concerns, these were about the current staffing issues such as use of agency staff who did not know people as well as more established staff, rather than about how caring individual staff were. For example, one family member said, "Mostly they treat [Person] very well, but the staffing levels and lack of communication between them is not good."

During our visit we met with people in their flats. We saw a number of interactions with staff and observed positive and comfortable relationships. We observed a person and a member of staff discussing a special family event and saw the staff were adapting the support needed with personal care in a dignified and flexible manner to enable them to be able to attend. We observed a person singing, "I love you" to the manager who demonstrated they had provided compassionate support which had enabled the person to return from hospital. We noted an affectionate and trusting relationship between the manager and the person. A professional told us, "When I am in the building the staff have always been friendly and engaged with passing residents. There seems to be a good and positive atmosphere at William Wood House."

While most staff interacted positively with people we saw one example where a member of staff was very task based when they supported people. We discussed this with the manager and they told us dignity training had been arranged to help staff understand the impact of their actions on the wellbeing of the people they supported.

We noted the manager promoted a respect for people's right to make choices about the life they leaded. The manager described how concerns had been raised by staff about certain decisions a person had made. While these had been investigated fully, the manager explained, "This is how [Person] wants to live," and described how they had discussed this with staff. This positive ethos could be seen in care plans, which were written in an empowering way to prompt staff to respect people's rights to make their own decision. For example, staff were advised to encourage a person to sleep in their bed but respect their choice if they chose to sleep in an armchair.

Support had been designed creatively to encourage people to accept support which promoted their wellbeing. For example, one person was reluctant to engage in personal care unless they were going out so staff encouraged them to go to regular activities which meant they accepted support. In another person's care plan staff were advised that if they refused care the staff should, "go and support another tenant, come back, talk about the good times, offer a drink and then offer care again. Staff should only then record that the person had chosen to refuse care."

There was helpful advice to staff about how to communicate with people, for example staff were told to give

a person with dementia "time to take in what you have said." Care plans included a "This is me form" which was completed where possible by family members to give staff an understanding of their life histories.

People were treated with dignity and their privacy was respected, for example when they received personal care. Relatives told us, "The carers always respect [Person's] dignity when they help them shower, they are very respectful" and "All the carers are really respectful - friendly but professional." A person told us, "They respect everything when they are here. They have a laugh and a joke but never go too far." Staff respected people's flats were their own homes. One person told us, "They always knock, even if I've told them not to bother, you know if they've just gone to get something and they will be back, I'll say just come in, but they never do, always knock first."

Good

Is the service responsive?

Our findings

Each person had a set number of care and support visits a day with agreed tasks assigned to each visit. The manager worked well with people to ensure this was in line with their preferences. A person told us, "I set the time that they come in the morning to help with showering." Staff also monitored people's wellbeing and provided support if required, for example in an emergency or to provide for one-off care needs. People told us staff would knock and look in on passing, just to check they were well. One person told us, "Staff will sometimes knock and pop their head in just to see if we are OK."

Adjusting support to people's changing needs was an on-going challenge at the service. Staff and the manager were constantly communicating with people about their care needs. For instance, following a fall a person's care needs had temporarily been met by two staff, until they had recovered their mobility. We saw staff reviewed people's care plans, usually annually or when their needs changed. There was scope for improved recording of discussions with people to ensure staff captured people's views when reviewing their care.

Staff recorded what support they provided each day, this was very task based so it was difficult to monitor changes over time. We discussed this with the manager who showed us they had sourced training to improve record keeping. They were also reviewing how best to record the ad hoc support they provided to people outside of their agreed visits, as this helped provide information where people had declining needs and might require increased support. The manager and staff told us there was often a delay when people's needs declined and the staffing hours were increased, which led to some dissatisfaction amongst staff, people and families.

Staff communicated through a handover book, which assisted them to provide consistent, personalised care. For instance, staff would communicate when outside professionals were visiting or when new equipment was being delivered. Although the book had not been used effectively to resolve the lack of medicines for a person, it generally appeared to work well to help staff keep in touch.

Care plans were written in a personalised manner. For example, where a person had poor eye sight they were told to offer a selection of clothes by describing them to enable the person to choose what they wanted to wear. There was clear guidance where staff involvement could have a negative impact on people. For example, staff had advice on how to introduce themselves to a person who saw their visits as intrusive. We saw that following an internal audit there was a focus by the manager to improve the guidance to staff to ensure it was more person centred and truly reflected people's needs.

People had their needs and risks assessed and the required support was outlined in detailed care and support plans. Support was tailored around people's choices and preferences. A person told us, "I make all my own choices" and a family member confirmed, "My relative will choose where to eat and what. They choose where and when to go out as well. The carers help with that." A member of staff had questioned whether people were having baths as required. When we discussed this with the manager they explained that if a bath was not part of the support plan a person would be offered a shower, though they gave some

examples when a person might be offered a bath, if staff had enough time.

There was a focus on supporting people to remain independent and where staff were providing support they were told exactly what elements a person could carry out. For example, a person who needed support with a hoist to transfer could continue attaching the loops from the sling and operate the hoists controls.

Staff received guidance about the appropriate level of communication required with family members, for example staff were told to text a relative when a person needed an item purchased. There was clear advice on who was responsible for specific tasks such as cleaning, laundry and shopping which helped ensure people received the right support from staff.

Complaints were managed well and used to improve the service. Concerns were logged, fully investigated and action taken to resolve any issues. The manager was open and pro-active when concerns were raised and they had escalated a specific concern for investigation by the area manager, to ensure a person could be assured it was being taken seriously. Feedback about the manager's response to complaints was particularly positive. Relatives told us, "I would call the manager who is always helpful;" "We would speak to the manager if we had any concerns at all;" and, "We have always found the manager to be helpful if we have any problems."

Good

Is the service well-led?

Our findings

On the whole, we received positive feedback about the manager and how well led the service was. For example, a family member told us, "The manager is marvellous and goes above and beyond. They actively encourage people to give their opinions and report issues. They really do operate an open door policy." Other family members said, "I think the manager is superb", "I would say it is well managed. The manager is always helpful" and "They keep me well informed." A person told us, "This is a smashing place and I feel I have really fallen on my feet in getting in here."

There were a small number of people, families and staff who gave us negative feedback. This tended to be about staffing issues or to specific incidents which had happened in relation to a person's care. Some comments indicated a lack of understanding of the model of care at the service. For instance, some family members spoke in relation to the lack of care support provided at night; however night time support at the service had been set up to meet security and emergency requirements rather than care needs.

We arrived to inspect the service on a Tuesday and met the new team leader and the manager who had both been providing direct care over the weekend and during part of the Monday. The pressure on staffing had been an on-going situation over a number of months. The manager explained that they were providing front line care to prioritise keeping people safe and well. A health and social care professional we spoke with told us that there had been issues with staffing and recruitment and the impact on people had been fairly minimal because of the commitment of a small group of staff who came in to fill any gaps. This pressure on a core staff team had led to a recent drop in morale.

Some routine management tasks and roles had not been completed recently, in line with the manager's and provider's expected standards, as the senior staff focussed on care priorities. The lack of senior oversight was evident in the medicine error which had happened as there had not been a well-coordinated approach and response which recognised the impact on the person of the delay. However, although we had concerns about this specific incident we noted that despite recent time constraints the manager had still ensured urgent improvements were driven through. For example, the manager had focused on assessing competence and managing poor practice where there were specific concerns, such as the administration of medicine, or poor timekeeping.

Other concerns highlighted during our inspection, such as low morale amongst staff and lack of communication between staff also indicated that the manager had not been able to focus their time on ensuring the team worked well together. However, when we looked at other concerns we saw they had been dealt with well by the manager although staff and families were not always aware of the wider picture. For example, the manager could describe in detail what they were doing in response to specific concerns, such as referrals to professionals for new equipment or requests to senior managers within the organisation for additional resources.

There was a new area manager who had been in place for less than a year. It was clear they were working well with the manager to improve the service, despite the staffing challenges. All the concerns which we

found throughout our inspection had already been recognised and were being addressed by the manager and provider. For example, more resources had been allocated to creating a new team leader post, to be in place shortly after our inspection. This key role would not only provide support to staff but free up the manager to carry out essential management tasks.

There had been a deterioration in the needs of people at the service which had impacted on the staffing pressures. The manager described to us the care needs of some of the people who had joined the service recently and they were largely more independent which helped address the pressure on staff time.

There was a wide ranging and practical action plan which was gradually improving the quality of the service. For instance, they had improved induction processes for agency staff and arranged training in dignity awareness, record keeping and medication. We were assured by the thoroughness and robustness of this response by both the manager and the provider.

There was good communication with people and their families. We saw that the manager had been open about the current challenge about staffing and had provided information about what they were doing to resolve the staffing issues. We also saw the provider was responding well to concerns about the role and responsibilities of the night time staff, for example there had been a recent survey consulting people on potential alternatives to the current provision. We saw that a survey of people's views about the service had taken place in the last 12 months and responses showed people were either very or fairly satisfied. Where specific issues had been raised these had been followed up individually by the manager, for example they had amended a care plan to show a person wanted female staff only.

The manager had an exceptional passion and commitment to supporting the people at the service. They were very visible and attended the service out of hours and at weekends. They were focussed on driving improvements and ensuring they developed a good team of care staff at the service who had a commitment to meeting the needs of the people they supported.

Regular checks on quality took place by the team leaders and the registered and area managers. These included checks on care and medication records. These were robust and led to improvements, for example one person's care plan had been amended with clearer information about the professionals involved in their care. Another check by the area manager had required all the manual handling risk assessments to be reviewed and revised where necessary, to provide staff with improved information. Whilst there had been a reduction in checks in the period leading up to our inspection, due to staffing issues, we could see there were robust systems in place and the current limitations were being resolved by the appointment of the additional team leader.