Parkcare Homes (No.2) Limited

Mount View House

Inspection report

Mount View House
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Rochdale
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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 is a small care home which can accommodate up to seven people with learning disabilities, autistic spectrum disorder or a mental health illness for younger or older people. It is located in Wardle which is on the outskirts of Rochdale. At the time of the inspection there were three people accommodated at the home.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, since the last manager left another person had been employed who had submitted all the required documentation to the CQC and was awaiting an interview for registration. This person was supported at the inspection by an area manager and other management staff.

We brought this inspection forward because of a complaint made by the member of the public..

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and homely in character. The environment was maintained at a good level and homely in character.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were given choices in the food they ate and where appropriate supported to shop or assist to make the meals. People were encouraged to eat and drink to ensure they were hydrated and well fed.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of her responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent

professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

Management conducted audits of the service and completed action plans to improve the service.

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.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were given a nutritious diet and supported to take foods suitable to their needs.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

Is the service caring?

Good

The service was caring.

We saw that staff had a kind and caring attitude with people who used the service.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

We saw that people were offered choice in many aspects of their lives and told us they felt they were treated with dignity.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns.

People were able to join in activities suitable to their age, gender and ethnicity. Staff took time to ensure any activities were suitable for each person.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they thought the new manager was supportive and led the service with a hands on approach.

Mount View 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 was an announced inspection and was conducted by two adult social care inspectors on the 06 December 2017. This was the first rated inspection for this new service.

We requested and received a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help plan the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also asked the local authority and Rochdale Healthwatch for their views about the service. They did not respond with any concerns. There had been some complaints from another local authority which we looked at during the inspection.

One person was able to communicate to us through an electronic device; we also spoke to two relatives, the manager, area manager, the positive behavioural support practitioner, two visiting professionals and two staff members. During our inspection we observed the support provided by staff in various areas of the home. We looked at the plans of care and medicines administration records for three people who used the service. We also looked at the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy available for staff to report any genuine concerns with no recriminations.

We looked at the ways people's finances were handled. There was a record of all transactions and receipts were retained for any purchases. This was signed by two staff when the money was withdrawn. There were audits to check the system and people's representatives had the option to look at the accounts. The system ensured people's money was kept safely.

We saw that there had been a safeguarding issue around one person accommodated at the home. We saw the service had investigated the incidents and responded promptly and appropriately. One of the lessons the service had learnt was to increase the security of the home following an incident. We saw that fences and gates were in place to prevent further risks to the public or the person who used the service.

Another lesson the service had learned was that one person did not respond well to meetings with many people called a MDT. This is a meeting between professionals, staff and family with the service user to discuss their care and treatment. The person had reacted badly and they were now held away from the person with the details passed on to the person later.

The service employed a positive behaviour support practitioner (PBSP). This was to formulate plans to safely look after people who had behaviours that challenge. We saw the plans had been updated regularly. Staff told us, "It is safe here. We have improved the security of the building and garden. I have never felt unsafe working here because we work well as a team to support each other. We have just had updated positive behaviour support plans put in place to help us manage people safely and all staff are undergoing refresher training so we can improve the way we do things" and "People are safe here, we have learnt from mistakes that have been made in the past."

We looked at the numbers of staff on duty on the day of the inspection. We saw there was the manager, deputy manager, a senior support worker, a positive behaviour support worker, five support workers and an administrator on duty. We saw that there was usually a manager and five or six care staff on duty at all times during the day and three staff at nights. This was the normal staff complement for this service. On the day of the inspection an area manager and clinical services manager also supported the staff team. We spoke with the managers about recruitment and we found that initially they had trouble recruiting staff in this rather remote location and had to use agency staff. We were told that the situation was slowly resolving itself. A staff member confirmed this when they told us, "We have had some challenges around staffing but we hope that this is improving and staff are really getting to know the people we support. We hope to make it a family environment."

We looked at four staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informed the service if a prospective staff member had a criminal record or been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that the electrical and oil installation and equipment had been serviced and had the relevant certificates. There were other certificates available to show that all necessary work had been undertaken, for example, portable appliance testing (PAT), the fire alarm system, emergency lighting and extinguishers. Staff also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. We undertook some checks and found water was at a safe temperature and the windows were safe.

We also saw there were regular checks that the fire system was working and fire drills held for staff to ensure they were aware of what to do in an emergency. There was a fire risk assessment for the building which had been completed by a professional organisation and reviewed by the manager. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in the care plans and near the entrance so staff could get hold of them in an emergency to present to the fire brigade. There was a business continuity plan for unforeseen emergencies such as a gas or power failure, severe weather or the loss of communications. The service had liaised with a local church to take people to if the building had to be evacuated in a hurry.

We looked at three plans of care during the inspection. We saw each plan of care contained an individual risk assessment for needs such as mobility, communication, personal hygiene, stranger awareness, bullying, vehicle use and challenging behaviour. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service.

There were also other risk assessments for environment safety, going out, community events, work or education attendance, slips, trips and falls and assisting in the kitchen. The risk assessments were developed to keep people safe and not restrict their movements.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service. Items in the kitchen such as knives were also stored safely.

During the tour of the building we noted the home was clean, warm, fresh smelling and in good decorative order. There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection. Staff we spoke with confirmed they had undertaken infection control training. The registered manager conducted infection control audits and checked the home was clean and tidy. People who used the service were encouraged to do as much as their abilities or behaviours would allow on any set day. This included keeping their rooms tidy.

There was a laundry sited away from food preparation area. There was a washer and dryer with other equipment such as an iron. This was sufficient at this service to look after people's laundry needs. No person who used the service had continence care needs.

We looked at the policies and procedures for the administration of medicines. The policies and procedures

informed staff of all aspects of medicines administration including ordering, storage and disposal. We saw the service complied with the policies. The service also had a copy of the National Institute of Clinical Excellence (NICE) guidelines to inform staff on safe administration which is currently considered best practice.

All staff who supported people to take their medicines had been trained to do so and had their competency checked to ensure they continued to safely administer medicines. The training was delivered by a recognised company and staff had to have three safe observations before being allowed to administer medicines.

Medicines were stored safely in a locked cupboard within a locked room. There were clear details for how the medicine was given, how often and by which route such as orally. The temperature of the room where medicines were stored was recorded daily and we saw that they were stored within manufacturer's guidelines. We saw one person had directions to take medicines at mealtimes. No person required covert administration or required stronger medicines called controlled drugs.

Patient information leaflets were retained for staff guidance and any side effects recorded in the plan of care. We looked at the medicines administration records (MAR) for three people and found they had been completed correctly with no gaps or omissions. Managers audited the system weekly to check for any errors.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

Accidents and incidents were recorded. The positive behaviour support practitioner recorded all incidents electronically and used the details to track any trends or patterns. The results were used to formulate proactive and reactive strategies to minimise any risks or de-escalate behaviours that challenge. This information was passed on to staff. Management audited all incidents monthly and any actions required were recorded.

We saw that the service had disciplinary procedures which were located in the staff handbook. We saw that they had been used following a safeguarding incident. This showed the service would use their procedures to protect people if they needed to.

Good

Is the service effective?

Our findings

We saw that the service used a variety of means and used technology to communicate with people who used the service. Each person communicated in a different way. One person used signs and an electronic tablet, one person liked to write down any communication and had a book and pencils and one person, although each day could be different, liked signs and visual aids. We saw that each person was able to communicate with staff in their preferred methods. We were invited to go into one person's room and sat with staff to communicate with the person who was very tactile. The person was able to show us they were going out in the afternoon using their tablet. The person also showed us their room.

We saw people were given information in a way they could best understand. For example one person had their own communication dictionary to express their views, including how to complain. Another person had communication aids around medicines using pictures and although the third person had several aids (Makaton and information boards) preferred to use an electronic IPod. Staff were able to assist people to communicate their needs. One person had a computer and was able to access information and use the internet.

We toured the building during the inspection and visited one person's private space, all communal areas and empty bedrooms. Two people accommodated at the home did not always react well to new people so we did not have any contact with them preferring to have minimal impact on the service.

The home was within a small cluster of buildings on the outskirts of Rochdale. Water to the home was provided by a spring which although there had been problems with the supply this had been resolved. There was a good sized car park and outside space which had been secured with fencing.

The lounges were domestic in style and contained sufficient seating for people to sit and relax and the dining room was able to accommodate all the people in the home although not everyone chose to sit together. Two of the three people mostly stayed within their private space which was set out like a small bedsit with a kitchenette and an en-suite shower and toilet. We saw one person's room was personalised with a television, their own bedding and personal belongings. We did feel that two people who lived in the apartments had limited access to the main building because of compatibility issues. However this was being addressed by the service with family members, social services and other professionals looking at the best way to make it workable for all.

The service had specific staff for assessing people's needs to deliver effective outcomes. Besides the plans of care, people's behaviours were analysed by specialist staff to enable them to spot triggers for behavioural issues. Although the service was relatively new, this approach can take some time, but we saw triggers for one person which had been identified included uncertainty (which included new people entering the home), illness, spending too much time in their room and the mention of Blackpool. By identifying the triggers responsible for setting off behavioural outbursts it was hoped to minimise them in future. Any restrictive practices staff had to use to de-escalate potentially dangerous behaviour was only done by staff who had been trained in recognised procedures. Staff had to attend a debriefing session after any incidents to

support them and talk through what had happened.

We looked at how the service met people's nutritional needs. Unlike a regular care home where meals are produced and a choice offered this could not be done at Mount View. Each person had their own likes and dislikes recorded and ate what they wanted on the day.

Where possible people prepared their own menu and one person assisted with the shopping and was able to order online with staff support. One person had quite a regular breakfast choice. In general people could have what they wanted for breakfast including a cooked option, had a lighter lunch and a main meal in the evening. Drinks could be had at any time and there was provision for a supper or a snack. Each person could, with staff support, help with meals in their kitchenettes or the main kitchen and were encouraged to do so. People's food likes and dislikes were recorded in the plans of care. We noted one person had a food allergy which was recorded in the plans of care to ensure staff were aware of this person's special needs.

The kitchen was rated as five star, very good from the last environmental health inspection which meant food ordering, storage, preparation and serving were safe. We went into the kitchen and found it to be clean and tidy. We saw there was a good supply of fresh, frozen, dried and canned foods. This included fresh fruit which was made available daily.

Although most items in the kitchen were locked away for safety reasons people had access to condiments and sauces to flavour their food.

We saw in the plans of care that people had access to any specialists if they had nutritional needs including a speech and language therapist (SALT). This had resulted in one person meals provided 'little and often'. We also saw that this person also required a special diet which was provided for her. Nobody at the home had any cultural or ethnic dietary needs or required fluid thickeners or supplements. We also saw that staff had found that one person ate better if they had a drink before meals which showed us people were treated as individuals.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). 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. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Most staff had completed training in the Mental Capacity Act and DoLS.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. In the plans of care we saw that each person had mental capacity assessments. The capacity assessments for one person included personal care, agreement to accommodation, finances, managed medicines and accessing the community. Following a best interest meeting a DoLS application was made to the relevant authorities. A best interest meeting is held for a person who lacks the mental capacity to make decisions for themselves and is undertaken by professionals, family members and the homes staff. A staff member said, "I understand about the principles of the MCA, we give people as much choice and control over their own lives here as possible. We have best interest meetings if we need to make a choice for someone."

We saw that the other two people could make decisions for themselves and had agreed to their care and treatment. We saw that one of the people accommodated at the home had also had a best interest meeting around restrictive practices, which was to be reviewed regularly to ensure the person understood what this meant for them. This helped protect people's rights.

A staff member said, "I am refreshing all my training at the moment, the induction and training are good and I have had a lot of experience on the job and was supported by more experienced staff, I am just completing the care certificate". New staff were enrolled on the care certificate and the homes induction program. The care certificate is considered to be best practice for staff new to the care industry. We saw documents which showed staff were working through the certificate. The induction provided by the service included familiarisation with the building and people who used the service, key policies and procedures and specialist training necessary for this home which included care of people with Autism and the use of communication aids such as Makaton. Staff were employed on a six month probationary period to ensure they settled into this working environment. New staff were trained and supported to care for the people accommodated at the home.

There was a system for checking when training had been completed or the next refresher was due on the services computer system. We were shown how the system worked. Training included all the mandatory training for example, first aid, fire safety, mental capacity and DoLS, moving and handling, health and safety, infection control and medicines administration. Training specifically aimed to support people who used the service included care of people with a learning disability, Autism and positive behaviour support. There was a well trained staff team.

Supervision was ongoing and held around every eight weeks. There was a yearly appraisal. Staff were able to bring up their training needs and discuss their careers at supervision as well as allowing managers to discuss performance. Some supervisions were also used to inform staff of people's needs for example communication. This helped staff support people who used the service. Staff told us they felt supported.

Good

Is the service caring?

Our findings

Although we were not easily able to communicate with people who used the service one person indicated they were happy at the service. We spoke to two family members who said, "I am concerned that he is not stimulated enough in the evening and is going to bed really early, he is a little isolated, it's not ideal. He has started to do more activities now during the day so this is promising. The staff are ok and I am made to feel welcome when I come to visit. I would like to be informed if an incident has occurred, this does not always happen" and "Some work needs to be done around the positive behaviour support interventions, I am not happy with some of it." We spoke with the relatives about the positive behaviour support staff member who said he had not spoken to the family yet because they were working on looking for trends or triggers. The staff member said they would talk to them regarding their thoughts around personal behaviour support. This relative also said, "The managers here are working with the commissioners and social worker to try to make things better, maybe looking at a move."

Two professionals we spoke told us, "We are always made to feel very welcome when we come to see [person] by the staff and we can access which records we need. They send through really good end of month updates, but we do not always receive these consistently" and "I think staff are doing a good job but I think there is still room to develop in terms of interacting with [person]. It's still early days. The staff decorated the new place to mirror where [the person] had lived before to make it as familiar as possible for them." Staff told us they enjoyed working at the service.

We observed staff interacting with people who used the service and staff were kind and sympathetic. One person who used the service had an emotional outburst whilst we were at the service. We could hear the person shouting but staff remained calm and did not raise their own voices. The situation settled and showed staff had the skills to defuse the situation. The manager and behaviour specialist went to assist staff and when they came back into the office discussed what had happened and what may have triggered the outburst and ways to try to prevent further episodes.

We did not see any breaches in people's privacy during the day, in regard to people's personal care or any discussions within earshot of other people who used the service. Records were stored securely and safely and only staff who needed to have access to the records did so.

We saw in the plans of care where people could do things for themselves this was recorded to inform staff. For example one person liked to apply their own face cream. Other people chose the way they wished to communicate. People were encouraged to assist with making meals, personal grooming and cleaning their rooms. This helped people retain some independence.

People were encouraged to remain in contact with their family and friends. One person's family visited the home. There were also arrangements made to phone relatives. One person had moved from another service and had contact with their relatives, which they had not had for some time.

People who used the service did not have any ethnic or cultural needs. However there were staff members of

both sexes should a person have a preference. Any specific needs were discussed with the person, family and supporting professionals and added to the plan of care. Plans of care contained documents showing how people wanted to be cared for which included a life story and a section on cultural beliefs. This would help staff treat people with equality and cater for their diverse needs.

Good

Is the service responsive?

Our findings

Each person who used the service had a plan which helped them raise any concerns in their chosen communication method. For example one person had access to the complaints procedure and was assisted by staff to write down any concerns. Other aids were used to allow people to raise their concerns including electronic devices, known aids such as Makaton and other pictorial communication support. One person was able to contact family members by telephone if they wanted support to raise any issues. We saw that complaints were recorded and acted upon. We saw that where one complaint was founded the service had admitted this and apologised to the member of the public involved. Action had been taken by the service to reduce the possibility of it occurring again. We also saw that where staff were at fault the service also took the necessary action. Complaints were audited each month which gave managers an insight into what had happened and any improvements that could be made added to their action plan.

People's needs were assessed prior to admission. The process could take some time, partly to find suitable people who were compatible with those already accommodated at the home and partly to ensure their needs could be met. This involved the person, their family members, staff from the service and other professionals who were involved in their care. We saw that for one person staff from where the person was moving from came to offer support and help the person settle in to their new home. One new person had been assessed by the service and a best interest meeting held to see if this was a suitable placement. We were told no decision had yet been reached. Arrangements were in place to find single accommodation for the person who was not very compatible with others. We asked about this person's initial assessment to move them into a multi-occupancy environment and were told their reaction had not been foreseen from the information and background history they had gained from all the professionals involved.

We looked at all three care plans during the inspection. Plans of care were detailed and individual to each person. Plans of care contained a past history (life story), a personal profile which was updated annually, likes and dislikes, how the person best wanted to be supported, what was important to them, personal aims and objectives, behavioural support, hobbies and interests, family support, social interaction, communication and other specific needs such as managing finances and cultural requirements. This formed the basis of each plan.

The support a person required was divided into headings for each need a person had, for example, communication, medication, safety and safeguarding, eating and drinking and mental capacity. The details gave staff the information required to look after each person and set out what support each individual needed. The plans were updated regularly and staff were informed of any changes.

We saw the service liaised well with other professionals regarding the care of each individual. People currently accommodated at the home were not from the local area. We saw that arrangements were in place for professionals involved with each person to visit the home to follow up on their progress and the service also sent out updates regularly to staff from the areas people had been admitted from. On the day of the inspection professionals were visiting one individual to check on their progress. Staff had a handover at the beginning of each shift. A handover gives oncoming staff an update on a person's care, any

appointments or trips out that need to be prepared for. We also saw that staff were given a debriefing following any behavioural incidents. This gave staff time to reflect on what had happened, if there were any triggers and was there a way it could have been handled differently. We saw management also discussed any issues and updated care plans accordingly.

People who used the service were assisted to go out to attend activities. Two people had their own transport. People were taken to places of interest such as the airport, for a drive or to the shops. Two of the people accommodated at the home were attending music and sensory sessions at a local centre. Other activities included cycling, arts and crafts, watching television or DVD's, going for walks to local beauty spots and other in house activities such as games. The person we spoke with said it could be a long process to find out what people liked or disliked or they could tolerate. The staff member said they were particularly pleased that one person was settling into music based activities which had not been tried before.

We were told one of the people was very clear about not going out in the dark and liked any activities to be planned. We also saw life skills were taught as part of the activity program which included maintaining personal care skills and planning meals/cooking. One person's family member thought stimulation in the evening was not sufficient. This person was prescribed medicines which helped maintain their sleep pattern, which was being reviewed to see if the person could remain awake longer. The person was being assisted into the main house for meals and for a relaxing bath in the evening to help stimulate the person to see what more could be done in the evening. In good weather there were plans for people to assist in the garden, which had been made secure for people to access safely.

Good

Is the service well-led?

Our findings

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, since the last manager left another person had been employed who had submitted all the required documentation to the CQC and was awaiting an interview for registration.

Staff we spoke with told us, "I feel well supported by the registered manager, recently we were supporting someone to an appointment and there was an incident, two of the managers came out immediately to support us, the registered manager is very hand on. The manager does not spend all his time in the office, he is very hands on and a part of the team" and "Things have settled down well since the new manager started, there have been loads of improvements and I feel well supported."

We looked at a range of policies and procedures which included confidentiality, data protection including the correct use of social media and networking, whistle blowing, safeguarding vulnerable adults, health and safety, lone working, infection prevention and control, medicines administration, anti-bullying and harassment and fire safety. The policies were readily available for staff to follow good practice and updated regularly to ensure they were fit for purpose.

Staff were also issued with a handbook which gave them information about the aims and objectives of the service, staying safe at work, the rules of working at the service, annual and special leave, learning and development, confidentiality, performance management and staff rights such as the grievance procedure. This was also recently reviewed to give staff up to date information.

The manager and area manager conducted regular audits to look at ways of maintaining or improving the service. At the monthly audit of November 2017 we saw the service looked at positive behaviour and support plans, physical intervention, safeguarding, plans of care, lessons learnt, medicines administration, key working, recruitment, training, supervision, best interest meetings and DoLS. We saw an action plan with timescales to complete any action and where required improvements made, for example staff were matched to people who used the service to be key workers, training was arranged (first aid and fire marshal) and documentation updated. The safety of the environment was also reviewed monthly to ensure the home was safe and functional.

Staff were able to attend meetings to have a say in how the service was run. At the last meeting of November 2017 topics on the agenda included a discussion of each person's care, training updates, positive behaviour support training, team building, Christmas, concerns, medicines administration, activities and any other items staff wished to bring up. Staff read and signed the meeting records which were held every three months.