Caulfield & Gopalla Partnership

Newnton House Residential Care Home

Inspection report

4 Newnton Close
London
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Tel: 02076905182

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 June 2018 and was announced. The provider was given 48 hours' notice because the location provides a service for adult men who may be out during the day, we needed to be sure that someone would be in. At our previous inspection in March 2017 we rated this service "Requires Improvement". We found two breaches of regulations with regards to safe care and treatment, and person-centred care. We also made a recommendation about the home recording verbal complaints. We found that the provider had taken satisfactory actions in response to the last inspection report.

Newnton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Newnton House provides care and support for up to 9 people with mental health needs, many of whom have a forensic history and learning disabilities. The service aims to provide a short-term service for people before they are able to live more independently. At the time of our inspection there were eight men using the service. The service is based in a large house in Hackney, which contains nine bedrooms, three bathrooms, a large lounge and activities room, a kitchen and dining area and a communal garden. There was a staff office within the building and a staff sleeping in room.

There was a registered manager at the service at the time of our inspection. 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 and associated Regulations about how the service is run.

People told us they felt safe with staff and there were enough staff to meet their needs. Staff were trained in safeguarding and knew how to safeguard people against harm and abuse. People's risk assessments were completed, regularly reviewed and gave sufficient information to staff on how to provide safe care. Staff kept detailed records of people's accidents and incidents. Staff wore appropriate protection equipment to prevent the risk of spread of infection. Medicines were stored and administered safely. The home environment was clean.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation protecting people who are unable to make decisions for themselves or whom the state has decided need to be deprived of their liberty in their own best interests. We saw people were able to choose what they ate and drank. People told us they enjoyed the food. The home was well decorated and adapted to meet their needs of the people.

People told us that they were well treated and the staff were caring. We found that care records were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff

members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service. People had access to a wide variety of activities.

The service had not recorded exploring people's wishes for end of life care. We have made a recommendation about involving people in decisions about their end of life care.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager was approachable and listened to concerns. The service had various quality assurance and monitoring mechanisms in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were recorded and administered safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff undertook regular training. Staff received regular supervision and appraisals.

The provider meet the requirements of the Mental Capacity Act (2005) to help ensure people's rights were protected. The registered manager and staff had a good understanding of Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink sufficient amounts and eat nutritious meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and to access health care services and professionals when they needed them.

Is the service caring?

Good

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how

to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint if they were unhappy about the home and felt confident their concerns would be dealt with appropriately.

The service had an end of life policy for people who used the service. However the service did not explore end of life wishes during the initial needs assessment and care planning stages.

People's cultural needs were respected. Most staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place. Staff told us they found the registered manager to be approachable.

People and health and social care professionals told us that the service was well run and they received good care.

The service had various quality assurance and monitoring systems in place.

Newnton House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 June 2018 and was announced. The provider was given 48 hours' notice because the location provides a service for adult men who may be out during the day, we needed to be sure that someone would be in. The inspection team consisted of one inspector.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, health and social care professionas and the local borough safeguarding adult's team.

During our inspection we spoke with the registered manager, the deputy manager, two care workers, and five people who used the service. We also spoke to a visiting health professional. We looked at four care files which included care plans and risk assessments, three staff files which included supervision records and recruitment records, quality assurance records, two medicine records, training information, policies and procedures, and complaint information.

Good

Is the service safe?

Our findings

During our previous inspection in March 2017, we found that risk assessments did not always contain sufficient strategies for managing and preventing behaviour which may challenge. During this inspection we checked to determine whether the required improvements had been made. We found the service was now meeting the regulation.

Care files each contained a set of risk assessments, which were up to date, detailed and reviewed regularly. These assessments identified the risks that people faced and the support they needed to prevent or appropriately manage these risks. Risk assessments included verbal and physical violence, physical health, drug and alcohol abuse, finances, absconding, hoarding, choking, medicines including self-medication, and mental health. Risk assessments identified the need for staff to be alert to the signs of a deterioration in people's mental health and to monitor people's compliance for example with their medicines and, where necessary, to escort people to access the community. Staff we spoke with understood people's mental health needs and possible triggers for behaviour which may challenge the service. Health and social care professionals we spoke confirmed the service knew people's risks well and managed them safely. Risk assessment processes were effective at keeping people safe from avoidable harm.

People told us they felt the service was safe. One person told us, "[Safe] as can be." Another person said, "I feel safe." A third person told us, "Yes feel safe."

There was a safeguarding policy in place which made it clear the responsibility for the provider to report any allegations of abuse to the local authority and the Care Quality Commission. Records showed staff had completed training in safeguarding adults. A staff member told us, "I would gather information and take to the manager." Another staff member said, "I would immediately go [to] my supervisor to report. If they did nothing I would go to CQC." The service had a whistleblowing procedure in place and staff were aware of their rights and responsibilities with regard to whistleblowing. This meant the provider ensured people were protected from avoidable harm and abuse.

The registered manager told us and we saw records that showed there had been four safeguarding incidents since the last inspection. The registered manager was able to describe the actions they had taken when the incidents had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Accident and incident policies were in place. Records showed there had been six incidents since the last inspection. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded. A health and social care professional told us, "[Staff] communicate issues relating to health and safety. They complete incidents report forms and share these with the clinical team."

Financial records showed no discrepancies in the record keeping. The service kept accurate records of any

money that was given to people and kept receipts of items that were bought. Financial records were signed by one member of staff and the person for each transaction and we saw records of this. Also, financial records were checked and signed at each handover. Records confirmed this. Where people were unable to manage their finances the provider had clear documentation such as the court of protection and Lasting Power of Attorney (LPA). LPA gives the power of attorney the power to make decisions regarding a person's finances. This minimised the chances of financial abuse occurring.

The service followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff had worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. One staff member told us, "I had to wait for my DBS and references [before starting work]."

People who used the service told us that they thought there were enough staff to support them safely. One person said, "Yes, enough staff. "Another person told us, "There are too many staff. I don't mind." Another person said, "Normally two or three staff. Manager is always here," Staff told us they were able to provide the support people needed. One staff member told us, "I believe there is enough staff." Another staff member said, "More than enough [staff]. There is a provision to cover [staffing] for holidays." Our observations throughout day showed sufficient staff were available to support people.

Medicines were stored securely in a locked cabinet in an office. We observed the office was locked when not in use. Excess stocks of medicines were kept in a locked storage room upstairs. There was a fridge for storing insulin, with temperatures of the fridge and storage areas checked daily, with clear guidelines for staff on what were suitable temperatures. There was also a sharps bin for disposing of used needles. We saw that bottles of medicines were labelled with the date they were opened, and records were maintained of stocks of medicines which were stored in the service. Medicines administration record sheets (MARS) were appropriately completed and signed by staff when people were given their medicines. Medicines records showed the amount held in stock tallied with the amounts recorded as being in stock. Training records confirmed that all staff who administered or handled medicines for people who lived in the home had received appropriate training. At the time of our inspection people were not receiving "pro re nata" (PRN) medicines. However, the service had PRN medicines guidelines in place. PRN medicines are those used as and when needed for specific situations. Staff told us one person self-medicated. Records confirmed the home had completed a risk assessment on self-medication and completed regular checks for this person that they were taking their medicines safely. This person told us, "My medication is kept in blister packs. [Staff] do a risk assessment and they check my MARS chart weekly." This meant people were receiving their medicines in a safe way.

Equipment checks and servicing were regularly carried out. The home had completed all relevant health and safety checks including fridge/freezer temperature checks, fire system and equipment tests, emergency lighting, gas safety, electrical checks, and water regulations. The home maintained a check sheet for ensuring that key checks to the safety of the building were up to date. This included employer's liability insurance, emergency lighting, portable appliance testing, fire alarm and fire detector testing, checks of fire extinguishers and gas and electrical safety. Staff had received training in health and safety and fire safety training, and carried out weekly tests of the fire alarm. Staff conducted quarterly fire drills in the service including recording whether people had been able to evacuate the service and follow instructions, and had scheduled future dates for these to take place. There was clear evacuation signage in place.

The home environment was clean and the home was free of malodour. One person told us, "It is a clean and tidy and nice environment to be in." The home managed the control and prevention of infection well.

Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control. Throughout the home information on hand cleaning was on display. The home employed a domestic assistant. One staff member told us, "When I am cooking I make sure surfaces are clean and wear gloves. We have PPE (personal protective equipment) available. We did [infection control] training." Another staff member said, "I wear gloves and apron when helping with a bath."

Good

Is the service effective?

Our findings

People who used the service told us they were supported by staff who had the skills to meet their needs. One person said, "[Staff] always checking on me."

Before admission to the home a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The assessment looked at medical diagnosis, medicines, background history, mental health history, current mental state, forensic history, physical health, social situation, finances, family and relationships. Records confirmed this. One person told us, "I was in hospital. The manager came to see me in hospital."

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "We have classroom training. I like it better than online. [Registered manager] encourages you to improve yourself like with extra training and advice." Records showed the training included safeguarding adults, breakaway techniques, moving and handling, challenging behaviour, equality and inclusion, lone-working, personal development, first aid and basic life support, infection control, medicines, care planning, diabetes, record keeping, fire training, food hygiene, consent, communication, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed that all the staff had completed the induction programme, which showed they had received training and support before starting work in the home. One staff member told us, "Induction was for three months."

Staff told us they received regular formal supervision and we saw records to confirm this. Topics included actions from the last supervision, health and safety, policies and procedures, updates on the people who used the service, shadowing, medicines, care plans and risk assessments, complaints, training and daily recording. One staff member said, "[Supervision] is monthly. For me it is a good experience. I say what I feel. We always find a solution." Another staff member said, "It happens monthly with the manager. My recent one was about training." Annual appraisals were being completed with staff.

The kitchen was clean, food items were stored appropriately and labelled. People had their own cupboard for their food which was lockable. People confirmed they had their own key for their food cupboard. One person said, "Food is in a locked cupboard and we all have our own key." Food hygiene notices were displayed in the kitchen. We saw records of fridge and freezer checks.

People told us that they had access to food and drinks throughout the day and were able to choose what they wanted to eat. Our observations confirmed this. One person told us, "I cook my own food. On a Sunday everyone has a roast dinner." Another person said, "Food is okay. I sometimes go out and buy takeaway." Food menus reflected the diverse cultural needs and preferences of the people who used the service. Food menus were developed from people's feedback recorded from the house meetings. Staff encouraged people to eat a healthy balanced diet. Some people had very specific dietary requirements. Records showed this was clearly documented in people's support plans and staff when asked knew people's dietary needs.

People were supported to maintain good health and to access healthcare services when required. Each

person had a health action plan. A health action plan is something the Government said that people with a learning disability should have. It helps people to make sure that the service had thought about people's health and that their health needs were being met. Records showed people visited a range of healthcare professionals such as GPs, district nurses, dentists, medicines reviews, and psychiatrists. One person told us, "We have a [GP]. I go to a [specialised clinic] every four weeks for a test and restock my medication." The same person said, "I had a heart attack last year. I had chest pain. I let the staff know and they were on the ball. They called an ambulance. They [staff] were very supportive when I came home." We spoke to a staff member about the person who had the heart attack. They told us, "I was the one who called the ambulance for [person]. I recognised the symptoms." A health and social care professional said, "They [staff] help [person] access physical health services [and] always bring [person] to appointments. [Staff] encourage individuals to have contact with professionals." This showed the service was seeking to meet people's health care needs.

The premises, décor and furnishings were maintained to a good standard. They provided people with a clean, tidy and comfortable home. There was a secure accessible garden for people's use. People's bedrooms were personalised.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most people had capacity for everyday decision making with some needing additional prompting and supervision from staff. One person said, "You can go out when you need to. I have keys for my bedroom and the front door." Another person told us, "Can go out when you want to." Records showed where people had been deprived of their liberty applications had been made to the local authority and best interests meetings had taken place in line with the MCA framework. Staff had completed MCA and DoLS training. Care records showed that staff had been involved in discussions during people's Care Programme Approach (CPA) meetings to give their opinions regarding people's capacity. CPA meetings are used to ensure that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty.

Consent to care and treatment forms were in care plans signed by people who used the service which included support being provided, and the sharing of health information. One person said, "They [staff] ask your permission with everything." One staff member told us, "I will ask to make an appointment for them. I will ask with everything to do with their life."

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "They [staff] are caring. They always know when I'm not myself and say we can have a chat." Another person told us, "They [staff] ask how you are doing." One health and social care professional said, "The staff treat [people] with care. They are warm-hearted, display kindness and concern for the [people]." Another health and care professional told us, "Newnton House have been exceptionally caring, safe and responsive in their management of [person who used the service]."

Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said, "I believe I have a good working relationship with [people who used the service]." Another staff member told us, "[People who used the service] appreciate you do good work. I have a mutual respect for them." Throughout the day we saw staff sitting with people engaging in conversation with laughter and kindness.

People told us they had regular key working sessions. One person said, "You go through the care plan with key worker. You meet whenever you need to which is pretty regular. If keyworker not here there is always someone who can go through the care plan." Staff knew the needs and preferences of the people they were caring for and supporting. Each person using the service had an assigned key worker. A keyworker is a staff member who is responsible for overseeing the care a person received and liaised with professionals or representatives involved in the person's life. One staff member said about key working, "I make sure living environment is fit for them. Key working sessions are to explore their feelings and make sure they follow their care plan." Records confirmed key working sessions were being regularly completed.

Care plans contained detailed information about people's communication needs and preferences. For example, one person who used the service did not speak English as their first language. The home had created a copy of the care plan in the person's language for them. Records confirmed it. The care plans helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. For example, one support plan stated, "I will bath or have a shower every other day and take my washing to the laundry area." Care records also contained information about people's background and personal history. A health and social care professional told us, "The staff appear to work creatively with [people who used the service] personalising the service for each [person]."

People's privacy and dignity was respected. One person said, "[Staff] leave me to be. They knock on my door. Not always in my face." Another person told us, "[Staff] respect my space." Staff we spoke with gave examples how they respect people's privacy. One staff member told us, "If I go to any room I knock on the door." Another staff member said, "Run the bath for [person]. I make sure no one comes in the room." A health and social professional told us, "[Staff] respect the [people who used the service]."

People's independence was encouraged. Staff gave examples how they involved people with doing certain aspects of their personal care and going out into the community to help become more independent. This was reflected in the care plans for people. For example, one care plan stated, "I will cook my own meals at least five times a week. I will clean my room twice a week. I will do my laundry every Wednesday. That means

that I will wash my clothes, my underwear and my bedding." One staff member told us, "I normally assist people with cleaning. We give them the option if they want to cook a meal. We give them the space to do what they need to do." Another staff member said, "Right now trying to get [person who used the service] become more independent with cooking, cleaning, and money."

Good

Is the service responsive?

Our findings

During our previous inspection in March 2017, we found that care plans did not contain sufficient information on people's preferences. During this inspection we checked to determine whether the required improvements had been made. We found the service was now meeting the regulation.

Care records contained detailed guidance for staff about how to meet people's needs. Care plans were in place for each identified area of need. People's care plans were easy to follow and provided details of individual routines. Pictorial aids were included in the care plans to ensure they were accessible to people. People who used the service and staff told us that care plans were updated following any changes to people's needs and were also reviewed regularly in order to ensure that they contained up to date information. One person told us, "I have a care plan for my medication and cookery. You go through the care plan." Another person said, "[Staff] go through the care plan every three weeks."

There was a wide variety of guidelines in people's care records regarding how people wished to receive care and support. Guidelines were recorded in people's care plans, communication passport and health action plan. The care and support recorded included physical health, mental health, activities, accommodation, medicines, eating habits, and being in the community. The care plan also included a section called 'These are the things that are important and matter to me' which reflected the person's goals and preferences. The care records were written in a person-centred way that reflected people's individual preferences. For example, one care record stated, "[Person's] right ear seemed to be most impaired so it can be helpful to speak to him through his left ear and ensure that he can see your face. Use my name [person] to indicate you wish to speak with me and make sure I am looking at you before you start to talk to me." Staff told us they read people's care plans and they demonstrated a good knowledge of the contents of these plans. Detailed care records enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People told us the service was responsive to their needs. One person said, "Staff are always there if you need them." One health and social care professional told us, "[Person who used the service] is someone who I thought would relapse very quickly in the community. I did not think Newnton House would be able to manage him. [Person] has managed to stay in the community for more than two years without recall. This is virtually a miracle." Another health and social care professional said, "I have always found the service responsive. [Staff] attend CPA meetings in the hospitals and attended ward rounds prior to discharge. They now attend the outpatient CPA meetings with the [person]. When I arrive to see [person], staff give me a good handover and ask for an update before I leave."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. One person who identified as LGBT told us, "[Staff] sometimes talk about being [LGBT]." The registered manager told us, "We need to meet their needs. Everyone has a life to lead." A staff member told us, "[Person who used the service] is [LGBT]. I would support them according to their needs."

People had opportunities to be involved in hobbies and interests of their choice. Most people who used the service had the capacity to make decisions about which activities they would participate in. From our observations and what people told us people liked to spend time in the garden, the lounge area and their bedroom. People were supported to engage in activities outside the home to ensure they were part of the local community. One person said, "I go to the shops with [person who used the service] and go out for a meal. We have Christmas and Easter parties, and barbeques." Another person told us, "I have enough things to do." A third person said, "I go to a place in Hackney to [play music]."

The home held a monthly house meeting where people could share and receive information. Records confirmed this. Topics discussed included housekeeping, fire alarm, activities, outings, holidays, food menu and choices, infection control and any other concerns. One person said, "[Staff] talk about any problems, any suggestions, if things could be run different and what is going on." Another person told us, "Talk about how you are doing."

There was a complaint process available. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised. There were systems to record the details of complaints, the investigations completed, actions taken as a result and the response to complainant. Records showed there had been three formal complaints since the last inspection. We found the complaints were investigated appropriately and the service had provided resolutions in a timely manner. The registered manager told us lessons had been learnt since the last inspection regarding complaints. For example, an issue had been raised during the last inspection regarding a person reporting to the inspector that a staff member had been verbally abusive. The registered manager completed an incident review of the complaint and looked at how this could have been avoided. The outcome of the review was shared with staff. Outcomes of the review were that the complaints procedure was reviewed and updated, staff to document all complaints received and additional training to be given. We saw from this inspection the complaints process was now more robust.

People told us they knew how to make a complaint. One person said, "I would speak to staff." Another person told us, "Complain to the manager in the office."

At the time of our inspection the service did not have any people receiving end of life care. After the inspection the home sent us their end of life policy which was appropriate for people who used the service. One staff member said, "We would liaise with the GP and the hospital, and other health professionals." The registered manager told us they were helping one person with burial choices however end of life wishes were not always recorded with people during the initial assessment and care planning stages. This meant there was a risk people did not have a chance to explore their end of life wishes and where they would like to spend the last stages of their life.

We recommend that the service seek advice and guidance from a reputable source, about the end of life care for people.

Good

Is the service well-led?

Our findings

People who used the service told us they liked registered manager and they thought the service was well managed. One person said, "[Registered manager] is a good guy. He is a nice bloke. He is there if you need him." Another person told us, "[Registered manager] is alright. He is ok."

After the inspection we received positive feedback from health and social care professionals regarding the registered manager and the service. Comments included, "I have found the service to be well-led and there appears to be respect for the management and all staff. The staff appear to work in collaboration with each other as a team", "They are well led. The staff are clearly on message about the work they need to do" and "I meet with the management of the service regularly. There is focus on providing individual needs that promote [people who used the service] recovery. There is open and fair culture."

There was a registered manager in post. They were aware of their responsibilities as registered manager and of the need to notify CQC about reportable incidents. They had current policies and procedures in place to run the service.

Staff spoke positively about the registered manager. One staff member told us, "[Registered manager] is a very direct but willing to listen. He is very approachable." A second staff member said, "I like him. He is helpful. Very helpful when you need advice."

The registered manager described in detail the support provided to people, and knew them, their preferences and needs well. They had built up a strong relationship with people who used the service. The registered manager had a strong focus on continuous learning for the service. This included the registered managers' own learning and development. The registered manager told us, "I'm a qualified mental health nurse and general nurse. I have a masters in health and social care management. I've started Level 5 NVQ [Diploma in Management & Leadership]."

The home held regular staff meetings where staff could receive up to date information and share feedback and ideas. Topics included in staff meetings were staffing, updates on people who used the service, referrals, house maintenance, health and safety, incident report, key working, risk assessments, person-centred care and outcomes. One staff member told us, "The last [staff meeting] was in regards to teamwork and putting together a leaving do for [person who used the service] moving on." Another staff member said, "Everyone has the opportunity to say something."

The provider had a number of quality monitoring systems in place. Regular quality checks were carried out by a director from the provider, which was called a 'person in charge' visit. This visit was used to monitor staffing files, staff on duty, training, supervisions, feedback from people who used the service, medicines, finances, care records, environment, food, and health and safety. The director checked that identified issues from their last visit were addressed on their return. Records confirmed this.

There were systems in place to monitor people's satisfaction with the service, this included supporting

people to carry out a satisfaction survey. The same satisfaction survey was sent to people who used the service, relatives and stakeholders so it was unclear when they were returned who had completed the form. We spoke to the registered manager about this and he advised he would update the satisfaction surveys to be specific to the groups it is meant for. Records showed four satisfaction surveys had been returned and were overall positive. One comment included was, "I find the staff very helpful to the residents."

Feedback received confirmed there was a good working relationship between the staff and the community mental health professionals. From our discussions with the staff, they told us they had a good working relationship with health care professionals. Records showed the service received feedback and updates from other services involved in supporting people, for example mental health teams, district nurses, social services, and health services. This information was contained within the care files and ensured that the service was working together with other professionals involved in people's care. One health and social professional told us, "Staff seems caring and understanding of the needs of my patients and the other residents in general. The communication with staff has been proactive and efficient."