Community Integrated Care

Henesy House

Inspection report

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Date of inspection visit:
14 September 2016

Date of publication:
02 December 2016

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

Henesy House provides a care home and rehabilitation service without nursing for a maximum of 17 people. However, the service adopts a clinical approach as it is comprehensively supported by a multi-disciplinary team which includes nurses and other health professionals such as physiotherapists, GPs and speech and language therapy professionals. We found the service provided care primarily for people over the age of 65 and we discussed the registration with the registered manager on the day of inspection as they had notified us that they provided care primarily for the service user band, younger adults. They told us they would apply to change their service user band.

The service supports people with rehabilitation and to care for themselves independently before returning to their own homes following a life event such as a hospital admission or an illness. A multi-disciplinary team was on site that supported people, including rehabilitation workers, physiotherapists, occupational therapists, pharmacists and nurses. There was also a GP attached to the service. People's stays were usually for an initial period of six weeks with regular reviews.

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

Medicines were safely handled to protect people. Risks were comprehensively assessed and plans were put in place to minimise these. Risk plans were subject to weekly review in consultation with people.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the service. The service had sufficient suitable staff to care for people and staff were safely recruited. The environment was safe for people and monitoring checks were regularly carried out. People were protected by the infection control procedures in the service.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLS.

People's nutrition and hydration needs were met. People enjoyed the meals. Specialist advice around people's health care and rehabilitation needs was sought from the multi-disciplinary team on site and from other specialists when required, and this was followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst

treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date and reviewed at least weekly. People were given opportunities to take part in drawing up their care plans, their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Everyone we spoke with told us that if they had concerns they were always addressed by the registered manager who responded quickly.

The service had an effective quality assurance system in place. Henesy House was well managed and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who were important to them, staff and health care professionals, in order to identify required improvements and put these in place. Records around good governance were clear and accurate and led to planned improvements.

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.

People were protected from the risks of acquiring infection because the service had good infection control policies and procedures and staff acted on these.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The registered provider met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people.

Staff involved people in decisions.

Staff had respect for people's privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the service and of staff. People were consulted about their views and their wishes were acted upon.

Henesy 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 registered 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 14 September 2016 and was carried out by one adult social care inspector and a specialist advisor who had expert nursing knowledge. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

During the inspection visit we spoke with seven people who lived at the service, six visitors, five members of care staff, a member of domestic staff, a cook, an office based person who provided administrative support and the registered manager. We also spoke with a Speech and Language Therapist, a nurse who was a member of the multi-disciplinary team and a pharmacist.

We looked at all areas of the service, including people's bedrooms, when they were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at six people's care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for four members of staff. We also observed the lunchtime experience and interactions between staff and people living at the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, "I feel so secure here. There are nurses and doctors, and all the medical staff close by. If there are any problems they are just there to ask." Another person said, "There are plenty of staff to help you all day and night. I only have to ask and they come straight away, and they are very cheerful about it." A visitor told us, "This place is really fantastic. They understand how to push just enough to help [my relative] to improve. Their confidence has shot up since they were here." Another relative said, "They discuss all the risks with us, and we know what has to be in place when they come home."

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the service procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us they calculated this using the numbers and dependency levels of the people living at the service at any time. Staff told us and we observed that there were sufficient staff on duty with a consideration of skill mix and experience to care for people safely. During the day times where the shift pattern was from eight in the morning until eight at night, there was one senior care worker on duty with two care staff, the registered manager, domestic staff, the cook and kitchen assistant and activities worker. Clinical visits took place from the multi-disciplinary medical team on site. On Thursdays, when the multi-disciplinary review meetings took place, an extra senior staff was on duty. This was to compensate for staff leaving their direct caring duties to contribute to these meetings. At weekends when there were no medical staff on duty, the staffing levels were also raised to include one extra member of staff. The registered manager sometimes used agency staff, but they told us they tended to use the same agency staff regularly, and that this was at not more than 25% of the total staffing complement to minimise disruption to people's care.

Staff told us that they had time for handover between shifts so that important information about people's care could be shared. A nurse from the multi-disciplinary team told us they received a full handover at the beginning of each day from night staff.

When there were no medical staff on duty during the night and at weekends, staff were able to explain how they would raise support and assistance from the on call staff and the crisis team.

We looked at the recruitment records for four staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS)

for each member of staff and that two references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the service had taken steps to reduce the risk of employing unsuitable staff.

Care plans identified a person's level of risk and records showed that these were updated weekly or more frequently if necessary to reflect people's changing needs. When they were able to do so, people told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. Risk assessments were proportionate and included information for staff on how to reduce identified risks while avoiding undue restriction. They focused upon enablement and how the person may regain independence during the time they were at the service. Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the service had an open and positive approach towards managing risk. For example, they had a breakfast club where people were supported to regain independent kitchen skills and to make their own meals.

Each person had a falls risk assessment and a falls profile on admission, (a falls bundle) and strategies for dealing with falling risks were individually drawn up. Linked risk factors were highlighted, such as prescribed medicines, or medical conditions. If a person should experience a fall, a post fall analysis was carried out and identified actions or interventions were recorded. For example, we saw that one analysis identified the need for a falls sensor by the person's bed. Each person also had a pressure care and skin integrity risk assessment carried out on admission (a skin bundle). This recorded people's skin condition, their weight and other risk factors such as their mobility with plans in place to minimise the associated risks. These were regularly reviewed, at least weekly but more often when necessary and were discussed at the weekly multi-disciplinary meeting along with other clinical risks.

Accidents and incidents were recorded and the registered manager explained that they analysed these for trends so that the risk of further incidents was minimised.

In the Provider Information Record (PIR) the registered manager stated that the service carried out a number of safety checks and audits to the building and grounds. Records confirmed that regular checks took place and that any identified shortfalls were addressed. The environment supported safe movement around the building and there were no obstructions.

The registered provider had a fire risk assessment in place and all firefighting equipment was regularly serviced to ensure it remained safe for use. Each person had a personal emergency evacuation plan (PEEP) which was easily available in case an emergency occurred.

Suitable arrangements were in place to ensure that medicines were safely handled. Where people were preparing for a return home they were supported to manage their own medicines with risk assessments in place to ensure that this was done appropriately. The registered provider used a Monitored Dosage System (MDS). MDS is a medication storage device designed to simplify the administration of solid oral dose medication. For those medicines which were administered by staff, the responsible staff member opened the MDS blister pack, bottle or packet only when the person was about to take the medicine. This reduced the risk of cross infection and error. After the medicine was administered the member of staff recorded this immediately. Codes were used appropriately on the Medicine Administration Records (MARs), for example when medicines were refused or destroyed.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their

potential for misuse. This meant that people were protected around the management of CDs.

We observed part of a medicines round. Medicines were administered safely and signed for immediately following administration. The member of staff we spoke with was knowledgeable about people's medicines and why certain medicines were necessary. Nurses with responsibility for administering medicines had received training. The registered manager carried out regular medicine administration competency observations to ensure nursing staff were following safe medicines practice.

Every person was provided with details on what each medication has been prescribed for and advised on any side effects to watch out for; particularly dizziness or lowering of blood pressure. This meant the registered provider adopted a partnership approach to medication management.

Pharmacy cover and support was provided by the acute trust. A pharmacy technician said they had confidence in the home's management of medicines and administration processes. The pharmacist played an active part in the initial and on-going assessment of people's medicine needs. People were actively encouraged to manage their own medicine administration wherever possible in order to prompt independence when returning home. Each person had a lockable cabinet in their room. This meant people were supported to be independent with their medicines which prepared them for being at home. Consent was obtained to ensure the person agreed to accept responsibility for safekeeping their own medication if it was assessed that they were safe to do so. The technician often undertook a home visit; particularly where there had been a major change of medication. On discharge home, the pharmacy staff undertook a review by telephone. This meant that people received continuity of care and support around their medicines while at the service and afterwards as they were settling back into their home routine.

The service had a policy and procedure around medicines which took into account the requirements of the Mental Capacity Act (MCA) (2005), homely remedies and those medicines which are taken as required, (PRN).

We observed that staff wore protective aprons at mealtimes which is good practice and in line with infection prevention and control measures. Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection, and told us they worked to cleaning schedules with clear instructions on which areas to deep clean and when. They showed us that cleaning equipment was colour coded to reduce the risk of cross infection. Staff understood the importance of using aprons and gloves and told us that they washed their hands frequently and always between offering care to people. The registered provider had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. Sanitising gels were available around the service. Bathrooms, toilets and people's individual rooms had wall mounted soap dispensers, lever operated taps and paper towels in line with current National Institute for Health and Care Excellence best practice guidelines, (NICE). The laundry room had a suitable washing machine and dryer. Dirty and clean laundry was kept separate and laundry was stored in colour coded bags in line with best practice advice.

Good

Is the service effective?

Our findings

People told us that the staff met their health needs and that they enjoyed the meals. One person said, "We get to see the medical team often, I've had someone to see me about physio and someone came about eating and drinking." Another person said, "I am much better at walking and have come along with making a cup of tea since I arrived here. The staff are all really helpful." One person had written in a survey carried out by the service, "The kitchen staff cooked nice meals and good portions, good choice of food." They went on, "The staff were helpful and consistent in improving my mobility. The regular exercise and physio work has contributed to my much improved mobility." In the 2016 patient satisfaction service audit carried out by the service, 86% of those surveyed said that the service had improved their independence and quality of life.

Each member of staff had an induction to the service. Staff confirmed that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the service. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff told us about the care a person required including how they should be supported with their medicines, how to support the person to move safely and how other risks should be managed around their care.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they were confident. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the service. The registered manager told us about the training they considered mandatory in the PIR. Staff told us about other additional training such as skin care, dementia care and stroke training. Training was delivered in a variety of ways according to what was most appropriate. This included e- learning and externally provided face to face training. In addition the registered provider had champions for falls, dementia, moving and handling, infection control and health and safety. These champions acted as a source of expert knowledge in their field and ensured that care pathways followed best practice advice.

Staff told us that they received regular supervision and appraisal. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

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 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions.

People's need for advocacy involvement was assessed and recorded. The registered provider had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions. There had been no applications by the service for DoLS. The registered manager explained that as the service focused upon rehabilitation services, most people only stayed with them for a short time until they were able manage at home. Most people had the capacity to decide things for themselves and none of the people living at the service required a DoLS application to care for them safely.

The registered manager told us that decisions which would need to be made in a person's best interests would be recorded and evidence provided that this was carried out with a multi-disciplinary team approach as the MCA advises. However, because of the nature of the service, most people had capacity to make their own decisions and so best interests decisions were not required.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and waited for a response. Care records also showed that people's consent to care and treatment was sought across a range of areas such as for photographs, care planning and any interventions. People's choices about their care were recorded for staff to follow.

The living environment had been organised so that people were supported with their needs. Although the building was generally tired and in need of decoration, there were no obstructions and people could move about the home unimpeded.

The registered provider had links with a multi-disciplinary team of specialists who were located on site, for example, physiotherapists, speech and language therapists (SALT), mental health professionals and a GP attached to the service. Advice from specialists was written into care plans and daily notes confirmed that the advice was being followed. This advice helped staff to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person. The skin integrity and pressure ulcer assessments were carried out using the latest PURPOSE-T assessment protocol

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. Risk assessments were in place around clinical care. The registered provider used the malnutrition universal screening tool (MUST) which is a recognised risk assessment tool to determine whether people are at risk of malnutrition.

Food, fluid and turning/monitoring charts were in place to protect people where necessary. Those we checked were accurately completed with no gaps and reflected the guidance set down in the care plan and risk assessments. This ensured that the registered manager could monitor whether people were receiving appropriate food and drink for their needs.

The registered provider provided planned and structured menus which took into account people's preferences. Menus showed that meals were nutritious, balanced and enriched where required. Staff

confirmed that people were provided with a choice of meals and that specific diets were catered for.

Care plans contained information about people's food likes and dislikes. Those people we spoke with told us their preferences around food were respected. Allergies in relation to food or drink were also recorded. Specific diets to take account of medical conditions such as diabetes were recorded and any fortified or prescribed supplements in use. This meant that people's needs in relation to food and drink were assessed and provided for.

We observed a lunch time meal where a hot meal was served and appeared of a good quality and quantity. Three care workers were supporting people at this time. This meant that staff were nearby at all times to assist people. We observed that people were provided with adapted cutlery and crockery. The food was well presented and people were given choices of drinks to have with their meal. Care workers were attentive to people's needs, and sat with them at eye level when they were supporting them with eating. This meant that staff responded to people's needs regarding support whilst eating and drinking. Snacks and drinks were available throughout the day and healthy foods such as fruit was available and in sight for people to help themselves.

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and respect. For example one person said, "They are really special here. They have all the time in the world for you and take time to explain things." Another person said, "It's a family atmosphere. They have looked after me so well I will miss them when I go home." People had written positive comments in the feedback forms they completed when their short stay had ended. Recent examples were, "People are very caring and always answer the bell. I just can't fault it." Another person had written, "I think they look after you so well. Always very pleasant." Another person had written, "From the first day I arrived I have been overwhelmed by the happiness and smiles of all. They can't do enough for you, nothing is too much trouble. I have been really happy here." Another comment was, "I felt very happy with the treatment I received and the courtesy shown to me."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses. Those people who were in discomfort were attended to with kindness. Staff reassured people where this was appropriate and showed that they were aware of people's likes and dislikes, those people who were important to them and details of their personal history. Examples of positive interactions were staff chatting and laughing with people, sitting quietly with people offering reassuring support and talking with people about their care plans and goals for the future.

We observed that staff approached people with respect and concern for their dignity. Staff told us that they respected people's right to privacy and dignity and we observed that they spoke using a kind tone of voice, listened to people and supported people discreetly and in a way which made them feel comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support.

People were assessed when required around their need for advocates or Independent Mental Capacity Advocates (IMCAs) so that their voices and wishes could be heard and acted on. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

The registered manager or senior staff had organised for people who needed them to have communication aids so that they could make an informed decision about options open to them. This included support to attend sight and hearing tests, and to have dental check-ups. People were involved in the day to day life of the service and almost all people chose to spend their time in the communal areas or on outings or visits rather than in their rooms.

People were involved in their care plans, and supported to make choices and decisions about their care. They were consulted at each weekly reviews and at other times when relevant. Evidence for this was provided in care plan documents, meeting minutes and daily notes.

Good

Is the service responsive?

Our findings

People told us that the staff were responsive to their needs. One person said, "They have reduced what they do for me as I have got better. I am much improved and they have been pushing me to do more in the kitchen. I know I can do it now." Another person said, "I had a period of time when I seemed to go backwards, the improvement wasn't so good. Then they discovered I had an infection and once that was sorted out I went on well with their help," and, "I have enjoyed the quiz games which helped me mentally."

The staff held a regular 'speak out' meeting which was specifically for people who used the service to air their views. Staff supported people to give their views, minutes were taken, and actions were recorded when people had identified required improvements. One person said, "They do something about it when you say something could be better."

People gave us an account of the care they had agreed to. They told us that staff consulted with them while completing their care plans and we saw that they had signed their plans. The registered manager told us that people were involved in drawing up their care plans as soon as they were admitted. They were introduced to the multi-disciplinary team and worked with the team to identify their goals. We saw examples of care plans which showed that this was the case. People's goals were described with details of how these would be reached. Plans followed the SMART criteria meaning they were specific, measurable, attainable, relevant and timely.

We saw that care plans were reviewed at least each week during the multi-disciplinary meeting. It was clear from the records that people had been involved and their views were included in the meeting minutes. Reviews focused on wellbeing, progress towards goals and any improvements which could be made to people's care. Relevant specialists in the multi-disciplinary team were consulted for advice at these reviews. Weekly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care. Care conferences were held to discuss the care of every person whose care programme was not meeting the expected outcomes. This meant that the registered provider responded to changes in clinical care needs. A clinical governance meeting was held monthly which gave oversight to the clinical pathways adopted by the service. The registered manager ensured that the person and staff were informed of any changes to clinical care which were introduced and that they had the opportunity to comments on proposed changes.

People had identified areas of interest, likes, dislikes and preferences within their care plans. Plans contained information such as what was important to people, family and friendships, spiritual needs and ways to spend time.

Specific staff were employed to engage people in one to one or group activities according to their preference and what was beneficial to people's improvement. The registered provider employed activities workers whose role was to work exclusively with people to provide stimulation and entertainment. People's preferences around daily activities had been recorded and people told us that they enjoyed the variety of activities. Examples of activities were bingo, puzzles, memory work, making meals, baking and drawing. A

therapist visited the service to offer people massage.

We observed a group activity during an afternoon. People were laughing and chatting and clearly enjoying this. Visitors were involved in this activity and staff had created a positive, encouraging atmosphere. The registered provider kept an activities log which gave details of what each person had been doing, whether they enjoyed it and plans for further pastimes.

We observed staff encouraged people to chat with them and each other, and they listened to what people had to say, responding to their needs. We observed staff supporting people, explaining treatment with them. Staff took time to make sure people understood what they were saying and give people time to express themselves. Staff told us they learned about people through talking with them and their visitors, reading their care files, talking to other staff and the nurses.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs. Staff could tell us about people's care needs and how these had changed.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. The people we spoke with told us that they were confident that their concerns would be listened to and dealt with courteously. We saw a record of complaints and the outcomes with timescales to monitor how these were managed. When people made a formal complaint the registered manager told us they informed the person of the results of their investigation and consulted the person to check that they were happy with the outcome.

Good

Is the service well-led?

Our findings

People told us that the service was well managed. One person told us that they liked the registered manager and often saw them to chat to during the day. Another person said, "I think the place is well run, yes, it goes like clockwork and all for our benefit." A visitor told us, "The manager is really good, he listens to people and you can tell [they are] genuinely interested in them." Another person said, "They have it all worked out. They know what I need and the place goes on really well. Having all the medical staff on hand is a great thing, and it all fits together beautifully."

The service had a registered manager in place. They were supported in their role by senior staff, and by the registered provider of the service. The registered manager told us that the company's senior management offered good support and encouraged them to discuss issues in a positive way.

The registered manager held regular resident and visitors meetings called 'speak out'. We saw some sample minutes of these meetings which showed that they were used as opportunities to listen to people's views and to pass on information.

The registered manager carried out or had oversight of a range of audits to ensure that the service provided people with safe and good quality care. These included risk areas such as pressure care, infection control, falls, medicine handling, accidents, kitchen safety and fire safety. For example, a weekly audit of medicine stock was carried out to ensure medicines were safely stored and accounted for. CDs were checked twice daily at each handover. This ensured that CDs were checked appropriately and any anomalies could be highlighted and acted upon. A weekly Key Performance Indicator (KPI) report was produced across a range of areas including clinical outcomes and staff competency. This was easy to read and comprehensive. All KPIs were currently being met and in a number of cases, exceeded.

Where shortfalls were identified, an analysis was carried out with actions in place to minimise future risks. Lessons learned and reflections for future learning were recorded for staff discussion in meetings. The registered manager also carried out a regular walk around the building where they identified any issues, and spoke with people and staff. They told us that this supported them to be more visible around the service and to pick up on things which needed attention.

People and those who were important to them had the opportunity to complete a feedback form at the end of their stay at the rehabilitation centre. We saw examples of these. The registered manager told us that the feedback forms were analysed and any points for improvement were placed into an action plan for the service. We saw examples of actions plans which showed when action goals had been achieved. For example, we saw that the registered manager had analysed how people responded to their physiotherapy input and had worked with physiotherapists to ensure people felt they were getting the best out of their treatment.

Staff told us that the registered manager was extremely supportive, open and positive. They felt the registered manager listened to them and got things done, addressing any issues quickly. They held regular

staff meetings which gave them information and guidance to care for the people who lived at the service. Minutes were kept and identified actions were recorded. One health care professional commented, "The [registered manager] is fantastic. Anything you ask [them] to do [they] chase up. [They] get involved and are very proactive. [They] always wants to know how [they] can help." A member of staff said, "We can all have our say and the manager keeps it confidential. [They] follow up on concerns and are happy to pick the phone up and make calls." For example a member of staff told us that a person using the service had not been sure about whether they liked the look of a care home from the brochure so the registered manager had arranged for an afternoon visit so they could get a feel for the place. Staff reported that the registered manager took on work themselves and did not expect them to do everything. They appreciated this and felt it supported them in their role.

The registered provider had an up to date service user guide and statement of purpose which gave useful information to people who were planning a move into care. Policies and procedures were regularly updated to reflect any changes in legislation and the care given.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the service to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the service, which placed the people at the heart of care.

Notifications had been sent to the Care Quality Commission by the service as required and they also sent notifications to other bodies such as the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous occurrences Regulations (2013) (RIDDOR). This meant that the registered provider provided for external scrutiny of incidents and accidents so that people's wellbeing was protected.