Sue Ryder

Sue Ryder - Holme Hall

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 January 2017 and was unannounced. The inspection was to check that the registered provider was now meeting breaches of legal requirements we had identified at the last inspection on 9 November 2015. We asked the registered provider to take action to improve: Regulation 12: Safe care and treatment and Regulation 18: Staffing.

During this inspection we found that the registered provider had taken action to improve practices within the service in line with their action plan from March 2016. We found these improvements were sufficient to meet the requirements of Regulation 12 and 18. This meant the service had met the breaches of regulation imposed at the previous inspection.

Sue Ryder - Holme Hall is registered to provide care and support including nursing care for up to 40 people over the age of 18 years old with a range of neurological conditions including Brain Injury, Multiple Sclerosis, Huntington's Disease, Cerebral Palsy, Stroke and Parkinson's Disease. The service is located in Holme-on-Spalding-Moor in the East Riding of Yorkshire. At the time of this inspection there were 24 people using the service.

The service has three floors. The ground floor is used for communal space and administration, Blue floor is the first upstairs level and accommodates people with complex neurological conditions and Green floor is the second upstairs level and accommodates people who are more independent.

The registered provider is required to have a registered manager in post and at the time of our inspection the manager's application to register was being processed by the Care Quality Commission (CQC). 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the care staff had a good knowledge of how to keep people safe from harm and the staff had been employed following robust recruitment and selection processes.

We found that improvements had been made to the safe management of medicines. People received their medicines on time and as prescribed by their GP. The recording and administration of medicines was much better than at our previous visit and medicines were stored safely and disposed of appropriately.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

Improvements had been made to the frequency of staff supervisions and the number of staff attending training sessions. People who used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. People had been included in planning menus and their feedback about the meals in the service had been listened to and acted on.

People were able to see their families as they wanted. There were no restrictions on when people could visit the service. We saw that staff were caring and people were happy with the care they received. People had access to community facilities and most participated in the activities provided in the service.

We observed good interactions between people who lived in the service and staff on the day of the inspection. We found that people received compassionate care from kind staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook support tasks.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that the manager met with people on a regular basis to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

The staff told us that the service was well managed. The manager monitored the quality of the service, supported the members of staff and ensured that there were effective communication and response systems in place for people who used 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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents.

There were sufficient numbers of staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People received appropriate healthcare support from specialists and health care professionals where needed.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when

supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs and their interests and preferences in order to provide a personalised service.

Staff supported people to maintain independent skills and to build their confidence in all areas.

The people who used the service were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well-led.

The service was without a registered manager. However, a registered manager's application was approved by CQC following this inspection.

People were at the heart of the service and staff continually strived to improve. Staff were supported by the manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the manager.

The manager and registered provider carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

Sue Ryder - Holme Hall

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 30 January 2017 and it was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to people with physical disabilities.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held about the service, including notifications, inspection reports and actions plans sent to us by the registered provider which outlined the actions they would take regarding the breaches identified at the previous inspection. The registered provider submitted a provider information return (PIR) in January 2017 within the given timescales for return. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the support services manager, the chief nurse for Sue Ryder national care services, the nursing lead for the service, the manager, two physiotherapy clinicians, the training administrator and five members of staff. People who used the service had complex neurological and often associated physical impairment which meant we were not able to hold significant discussions with them on their experience of the service. We exchanged pleasantries with some individuals and carried out observations during the inspection in the communal areas and during mealtimes. These observations helped us to understand the experience of people who could not communicate with us. We spoke with one relative face-to-face and telephoned two others to obtain their perceptions of the service.

We looked at two people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental

Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for five members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Good

Is the service safe?

Our findings

At the last inspection carried out in November 2015 we found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to safe management of medicines. We found the recording and administration of medicines was not being managed appropriately in the service.

At this inspection on 30 January 2017 we found that sufficient improvement had taken place and that the breach had been met.

We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, recorded correctly when administered by the staff and disposed of appropriately. The qualified nursing staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files. We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs).

The medication room keys were held by the nurse in charge of the shift. Controlled drugs (CDs) were regularly assessed by the nurses; stock levels were checked by us and found to be recorded accurately in the CD register. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature. The nurse was able to tell us about how they returned unused and unwanted medicines to the pharmacy supplier. There was a return medicines book in place and a cupboard for return medicines to be stored in. These were picked up by the pharmacy on a regular basis.

The service was safe. All appropriate doors had closure systems to prevent unauthorised entry/exit. Observations showed that there were sufficient staff on duty to meet people's needs and have time to carry out activities, physiotherapy sessions, or sit and talk with people who used the service. The duty rotas showed that there was always someone in charge of the service in the form of the manager, service support manager or lead nurse. Staffing levels were high and the staff to people ratios observed in all contexts were appropriate for participation and safety in the activities of daily life.

On the day of this inspection there were eleven care staff on duty including qualified nurses for 24 people who used the service. There were three people who used the service requiring one-to-one input and these staff were part of the overall total of eleven on duty. The manager said the one-to-one shifts rotated during the day with different staff each taking a turn to reduce stress on the staff. There was a protocol in place so if a person receiving one-to-one input had expressed a preference not to be cared for by certain staff, then their wishes were respected by the service.

People were kept safe from abuse as the manager followed robust recruitment processes to ensure suitable

staff were employed. We also saw evidence that staff had undertaken safeguarding training at the appropriate level. The members of staff on duty were able to clearly describe how they would escalate concerns, both internally through their organisation or externally should they identify possible abuse. We received feedback from the local safeguarding team that, since the new manager had been in post, four alerts had been investigated by the safeguarding team. They told us, "The manager has dealt with the issues safely, effectively and according to protocol." The Care Quality Commission (CQC) had been notified of all the safeguarding issues.

We looked at the recruitment files of five members of staff and saw that safe recruitment practices had been followed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

People who were identified to be at risk had appropriate plans of care in place such as plans for managing pressure area care. Risk assessments covered areas such as mobility and falls, using the hoist and choking. Staff were able to tell us about the individual measures they put in place to keep people safe. The risk assessments and care plans we looked at had been reviewed and updated on a monthly basis. Charts were used to document positional changes and food and hydration intake. These records were accurately maintained. The records reflected the care we observed being given. This meant people were protected against the risk of harm because the registered provider had suitable arrangements in place.

Accidents and incidents were managed appropriately. There were few incidents each month but the registered manager discussed how they would analyse these. We saw that where accidents had occurred they had been fully recorded and appropriate remedial action taken. We saw that staff had received a range of training designed to equip them with the skills to deal with all types of incidents, including medical emergencies. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety, nurse call system, portable electrical items, the lift and hoists, electrical wiring and the gas system. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the staff, maintenance team and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

We saw that the fire risk assessment for the service was up to date and reviewed yearly. The people using the service each had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. We looked at the registered provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. It had been reviewed in the last year. These safety measures meant the risk of harm for people and staff was monitored and reduced as much as possible.

All areas we observed were very clean and had a pleasant odour. We saw that personal protective equipment (PPE) was available around the service and staff could explain to us when they needed to use protective equipment. Ample stocks of cleaning materials were available. We saw that the domestic staff had access to all the necessary control of substances hazardous to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

We saw the registered provider had an infection prevention and control audit (IPC) carried out in January 2017 by an external company. The action plan from the audit formed part of the services' quality improvement plan and a meeting with staff, to discuss the outcomes, had been scheduled for the week after our inspection. The manager told us that the IPC audit would be repeated in six months and after that on a yearly basis.

Good

Is the service effective?

Our findings

At the last inspection carried out in November 2015 we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to staffing. During our inspection we found that although there was an extensive training programme in place and there was a supervision plan for the staff, the training and supervision of staff was not always up to date.

At this inspection on 30 January 2017 we found that sufficient improvement had taken place and that the breach had been met.

We looked at induction and training records for five members of staff. The induction programme was role specific and carried out over four weeks. It included completing a range of training deemed by the registered provider as both essential and service specific. We saw documentation that indicated new staff were mentored by senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork. Staff had to complete clinical competencies within the first two months of employment. In the six month probation period new staff had one-to-one meetings with their line manager at the end of months one, two and three. Over months four to six the new staff had probation reviews and a development plan created with them.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity. The staff training plans showed that they were up to date with their refresher courses and had access to courses relating to neurological conditions and learning disabilities linked to the needs of people who used the service. The training plan also indicated that 88% of staff had completed training to help them manage agitated or distressed behaviours in a safe way without using restraint.

Checks of the staff files showed that all staff received regular supervision from their line manager and had a yearly appraisal of their work performance with the manager. Records seen indicated that supervision meetings were held every two to three months. One new member of staff told us they had just had their three month review. They said they felt well supported and found the induction, training and supervision process to be robust. We were told they attended staff meetings and had daily handovers which kept them up to date with any changes in the service. We saw that the manager sent staff weekly memos on a variety of subjects to keep them up to date with any changes in the service. The member of staff also spoke about using the information technology (IT) system called 'Huddle'. Each member of staff had their own password to access the system and from there they could access rotas and handover sheets so could catch up with events if they had been on leave.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (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. Where appropriate, people were subject to DoLS authorisations. People subject to DoLS had this recorded in their care records and the service maintained an audit of people subject to a DoLS so they knew when they were to expire. The registered manager and staff were aware of the person's right to contest the DoLS and apply to the Court of Protection for a review of this order.

Staff showed awareness of people's rights and MCA. In discussions staff were clear about how they gained consent prior to delivering care and treatment. For example, one member of staff knew to ask people for consent before giving care, but was also aware there were people who were cognitively impaired so followed their care plans, which were all individual and detailed about the support people needed.

People in Sue Ryder - Holme Hall received support and care from the multi disciplinary team (MDT) on a two weekly basis (Blue and Green floors alternate each week). Six people who received additional funding from the Neural Pathways Scheme received input each week from the MDT. We saw two people's 'Neural pathway' forms, which included notes and assessments from the multi-disciplinary team. The team included dieticians, occupational therapists, physiotherapists, GP and staff. The information was gathered through discussion with the person who used the service; looking at their life and what their future ambitions and goals were. The discussions included looking at medical conditions, recreational needs, physical capabilities and equipment needs. One of the people who received this evaluation had subsequently been able to receive funding for one-to-one input to improve their quality of life.

Care plans were updated by the therapy team and any concerns were documented. Issues with people's diet were raised with the speech and language therapy (SALT) team and the community dieticians. This indicated there was good partnership working between all health care professionals involved in people's care, which meant people had less delay in receiving appropriate treatment and care. The service had also invested in employing two part-time physiotherapists who were undertaking a comprehensive analysis of the service's support and recreational processes to identify ways of improving dignity, safety, independence and engagement by people who used the service. It was too early in the project to identify significant findings.

Communication between families and staff was good. Two relatives we spoke with were very satisfied with the safety and quality of care provided by the service. One relative told us, "I'm very pleased with the service. All staff are very supportive and responsive, advice on assisting with care is freely available. All physical needs are met and the feeding tube site cleanliness is maintained at a high level. My relative who uses the service is not in distress and I have no clinical concerns." The second relative said, "Care and nursing standards are excellent. The service responded swiftly to my concerns over a foot sore. My relative using the service is kept clean and there is good attention to their skin condition. Their care and contentment have improved clearly under the leadership of the new manager."

At our last inspection in November 2015 we noted that some people had to wait a while for support with eating and drinking, which meant the temperature of their meals may not have been as hot as they would

have wished. Observations of the meal times at this inspection showed improvements had been made.

We observed lunchtime in the dining room, which a minority of people who used the service attended. The majority of people chose to be served individually in their bedrooms. Some people were prevented from attending the dining room because of the severity of their medical condition or their immobility. We observed meals being served that reflected the dietary advice of dieticians as documented in people's care files. The quality and variety of meals were well received by people and clearly enjoyed.

A recent survey of people who used the service was carried out by a volunteer supporter of the service. The results showed high satisfaction with the standard mealtimes, but low satisfaction with the availability of snacks between meals. This last point was acknowledged by the manager and was being addressed. We noted that people could choose their menus the day before. We spoke with the cook who was knowledgeable about people's nutritional needs, and strongly committed to providing good quality food that reflected the choice of people who used the service.

During a tour of the premises in the company of the support services manager we observed spacious and well-maintained premises, including good-sized bedrooms and a variety of spacious communal areas, plus a substantial outdoor patio area which was reported to be popular in spring and summer. The atmosphere and environment in the service was positive and people's bedrooms were decorated and furnished to their individual taste. The bedrooms that we looked at were clean and safely organised. All areas we looked at were pleasantly warm and free from safety hazards.

Good

Is the service caring?

Our findings

We found the service to be calm and relaxed and as we walked around the building in the morning we saw that people were well presented and dressed appropriately for the weather. We asked people if they enjoyed living at the home and they responded by smiling and nodding their heads. People who used the service said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Appropriate specialist equipment was provided to each person according to their needs and staff were focused on providing a stimulating and safe environment. Staff told us they had a good range of equipment to help them meet people's needs including specialist beds and mattresses, hoists and slings, safe bed rails and that the environment was safe and secure. We saw one person with a very advanced stage of a complex neurological condition; they used equipment designed to avoid pressure ulcers and their bedroom was equipped to provide a calming environment. This room had been furnished and equipped in discussion with the person's family.

We observed people being treated with dignity and respect by staff. Staff engaged with people conversationally and for chosen activities appropriately. We noted that staff addressed people by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when completing care tasks. Interactions between staff and people were appropriately respectful and sought decision- making from each individual. There was an agreed staff perception, as reinforced by recent team training, of the mission and purpose of the service. This was, "Everyone should live the fullest life possible."

Staff interactions with people were universally positive and cheerful. Staff were focused about creating a welcoming, comfortable and stimulating residential experience. Within the activities and services on offer, there was focus on individual needs and in providing appropriate choices for people, including developing their independence where possible.

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. Staff gave us examples of how they had provided support to meet the diverse needs of people using the service. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in their care files. People were supported to maintain their spiritual, religious and cultural needs if this was what they wished to do. We saw that where people expressed a preference for female or male staff for giving their personal care, this was respected by the staff and documented in their care file.

The in-house laundry service was highly organised and effective, staffed by two employees with a combined seventeen years' experience at the service. They had set and maintained high standards for ensuring bedding and people's clothes, for example, were constantly clean and well ironed, thus providing the associated dignity for people. Everyone we saw was well dressed in appropriate clothing for the time of year.

People's attire reflected their personal tastes and choice of dress.

Staff were observed to be very positive and happy and they carried out care with compassion. There were opportunities for people to be alone and have privacy if they wished, if it was considered to be safe following a risk assessment for those who lacked capacity.

Information was provided, including in accessible formats, to help people understand the care available to them. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. An advocate is someone who supports a person so that their views are heard and their rights are upheld. The resident survey of mealtimes was a good example of consulting people on their needs. People had detailed care files. Their past medical history was recorded and any personal information was retained in the main care files which were kept locked away in the nurses' office. This helped maintain confidentiality.

Good

Is the service responsive?

Our findings

At the last inspection in November 2015 the service did not record how or when people had been involved in the development of their care plans. We saw no evidence to suggest that people were not receiving the care they required, but found that people's input to their on-going care was poorly recorded. We made a recommendation about improving the recording in the care plans, to show how people had input to the process of decision making with regard to their care and support. At this inspection we saw that improvements had been made to record keeping.

The staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People who used the service told us there were few or no restrictions on their daily life, although risk assessments had been completed and behaviour management plans were in place to make sure people stayed safe and well. Evidence in the care files showed us that people's views were sought and listened to, and that families were also involved in reviews of people's care.

People's care plans were detailed and person-centred. Families were encouraged to input to the care files where people were unable to contribute. Each of the care plans included details of the person's care needs, their wishes and aspirations in the area and any risks related to the need. This meant that people's care profiles included a wide range of information designed to assist staff to support them effectively. When people's needs changed this was clearly recorded.

People we spoke with were unable to tell us whether they were involved in their care planning, although they were very positive about the menu choice. The three relatives we spoke with were positive about staff attention and attitudes. One relative felt there could be more frequent dialogue between the service and them to keep them updated on any changes to the care plan. (This relative/carer was by their constant presence the de facto main family carer although not the Lasting Power of Attorney for the person who used the service.)

A power of attorney is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and / or finances) on behalf of a named person. The relative referred to above understood that they would have to make an application to the Court of Protection in order to be authorised to act on behalf of their family member with regard to finances and health and wellbeing.

Staff were respectful of people's spiritual needs, which were well catered for through a visiting chaplain and through the support services manager being a Church of England trainee lay reader. They had provided two services in recent months. These were well attended by both people who used the service and family

members.

Each person had a copy of their activity schedule in their bedroom. The range of equipment for the wide-ranging activities programme was observed as good. Staff numbers were sufficient to allow people a choice of activity and to enable participation by all those interested. We saw there was a research project in partnership with a local university in place in relation to the use of electronic games as a stimulus for people with neurological conditions. The goal of the physiotherapy analysis project was the identification of further opportunities for people to engage in activities safely and independently.

We observed and discussed with the recreational therapy co-ordinator the wide and varied range of activities provided throughout the week. People were assessed for their capacities to participate in individual or group activities and adjustments were made wherever possible to increase the number of participants. The range of recreational activities provided included arts and crafts, baking, games and video gaming. We observed people enjoying participating in a range of activities. Staff were flexible and responsive to individual people's needs and sought to adapt or create new experiences where possible. One-to-one support was provided to people where needed.

We were advised of opportunities for people to undertake trips outside the service. For example, two people and care staff were going for a local pub lunch on the next day. Until a few months ago, a highly capable person who used the service was able to independently attend external groups. This opportunity was still available to anyone else with the capability or inclination to contribute.

Staff were patient and encouraging in assisting people to participate in activities to meet their interests and provide stimulating engagement. One relative told us, "Yesterday's birthday party was very enjoyable and a happy experience for [Name]. I would not want them at any other home."

There was no restriction on visiting times, within reason. If families wished to be involved in the assisting of care delivery to a loved one this was incorporated in to the care plan. People's families were encouraged to make rooms as personalised as they wished with family photos and familiar items.

People had access to a copy of the registered provider's complaint policy and procedure in a format suitable for them to read and understand. We looked at the complaints folder and saw that six complaints had been made in the last year; all had been responded to appropriately and resolved.

We saw evidence during our inspection that the manager was in daily contact with people who used the service and was available to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

Good

Is the service well-led?

Our findings

At our last inspection in November 2015 we found that the manager monitored the quality of the service. However, further work was needed to ensure the audit system was robust. We made a recommendation about quality assurance in the report. At this inspection we found that improvements had been made to the quality assurance process.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC by January 2017. This was completed and returned with the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

At the time of our inspection the manager was waiting to be interviewed by CQC as part of their registration application. Since our inspection the registration process had been completed. The Chief Nurse for Sue Ryder homes stated that they had been providing closer monitoring of the service than usual during the last eight months to support the new manager and monitor the transition in service strategy from the previous senior leadership. They also reported that as their confidence in the new manager had grown they were able to reduce the extent of direct monitoring.

The registered provider was aware of the importance of forward planning to ensure the quality of service they provided could continue to develop. In our discussions with the manager, they articulated a coherent and rational philosophy and strategy for appropriately meeting clinical, behavioural and recreational needs of the people who used the service. This philosophy was shared by all other staff spoken with. We observed them carrying out their roles with enthusiasm and commitment.

Staff were articulate in explaining their role in the context of the service's mission which was to provide stimulating and interesting living experiences plus appropriate clinical and safety support. All the staff we met were happy, relaxed and promoted a positive atmosphere. They explained that they found their roles fulfilling. One member of staff told us, "I like it here, it is nice to look after people who are getting better."

Discussion with the manager showed that work was on-going to build up the morale of the staff as they had gone through a number of organisational changes over the last two years. This included changing the shift patterns from 15 hour shifts to 12.5 hours. We were told that the emphasis was to move the service culture firmly back to care home principles and away from that of a rehabilitation setting. A considerable investment of time and resource had been made in team building activities through recent events, which were attended by 95% of staff. One of the outcomes from the team building was the production of an 'ideas tree' where staff could add leaves with their suggestions of how to change cultures and practice. The manager told us it was expected to take 18 months to fully implement all the changes needed to move the service forward.

The service had an organisational development plan in place, with values and behaviours that staff signed up to. In November 2016 the team building work looked at these values and behaviours. Staff received

booklets and a team charter was developed and given to all the staff. This gave staff a clear oversight of what was expected of the service leaders, staff and people who used the service.

Staff in all areas of the service expressed confidence in the manager's leadership and felt they were well-led. They believed the culture of the service was appropriately focused on people's care, safety and quality of experience. Two staff group representatives provided feedback to the leadership team on service matters. Staff and relatives we conversed with, spoke highly of the positive impact on the culture and effectiveness of the service since the appointment to the lead role of the current manager.

All staff had received training in relation to the Equality Act and human rights over the last 12 months. The service was able to demonstrate in their service plan how they would build upon this learning to promote best practice. All staff were involved in the concept of 'Resident of the day' where the focus was on one person using the service. Each day of the month, one person's care and treatment was reviewed including care plans, menus, medicines, environment and equipment.

Feedback from people who used the service, relatives, health care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the registered provider and where necessary action was taken to make changes or improvements to the service.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in December 2016 and January 2017 and covered areas such as reportable incidents, recruitment, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We also saw that audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.