Brighton and Hove City Council

# Brighton & Hove City Council - Wayfield Avenue Resource Centre

**Inspection report**

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## Ratings

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|---|---|
| **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? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection took place on 11 November and 19 November 2015 and was unannounced.

Wayfield Avenue Resource Centre provides personal care and support for up to 24 people who have a diagnosed functional mental health need. Care and support is provided to adults over 40 years of age but predominantly to people over 50 years of age. At the time of the inspection the majority of people were over 60 years of age. Short-term transitional care is provided for a period of up to 12 weeks. This is to enable a further

# Summary of findings

period of assessment of peoples care and accommodation needs, and can be used to assist people to move out of hospital prior to moving into more permanent accommodation. Staff will support people to help maximise their independence, choice and dignity. There were also five people receiving long term care who have lived in the service for a number of years, prior to the changes to the services admissions criteria. Staff in the service worked closely with the Sussex Partnership NHS Trust. Regular visits were made from visiting psychiatrists and a registered mental nurse (RMN) was seconded to work in the service and provide support and guidance for staff. There were 22 people living in the service on the days of our inspection.

Wayfield Avenue Resource Centre is a two storey building. People with mobility issues were accommodated in the service, with a passenger lift for level access throughout the building. All the bedrooms were single occupancy with ensuite facilities. All lounges have kitchen and dining facilities. People were also able to use a garden area in the better weather.

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

The service was going through a significant period of review, where the provider and local stakeholders were looking at the service provision and what was needed and how the service would best be provided in the future.

There were limited opportunities for people to join in social activities in the service. This is an area that requires improvement.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Senior staff had policies and procedures to follow and demonstrated an awareness of where to get support and guidance when making a DoLS application. Care staff had received training or guidance on DoLS. They were aware of DoLS and who had a DoLS application agreed, and of the care to be provided and agreements as part of the DoLS application to be followed.

Senior staff monitored peoples dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training records were kept up-to-date and the registered manager audited the training records to ensure all staff had attended the required training to meet peoples care and support needs.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place for the proper and safe management of medicines.

People told us they felt safe. They knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. The service was clean was a maintenance programme in place which ensured repairs were carried out in a timely way. Regular checks had been completed to ensure equipment and services were in good working order.

People's individual care and support needs were assessed before they moved into the service. Care and support provided was personalised and based on the identified needs of each individual. People had a care and support plan and risk assessments in place, which had been reviewed. The detail for staff to follow was good and gave clear guidance for care staff to follow. One visiting professional told us they had found staff had an excellent understanding of people's complex needs. It had been clear that the people had benefited from the service they had received. Enough to be able to move into a more permanent service.

Charts were in place to monitor people's food and fluid intake and observations had been consistently recorded. Staff told us that communication throughout the service was usually good and included comprehensive handovers at the beginning of each shift and there were periodic staff meetings. They felt they knew people's care and support needs and were kept informed of any changes. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs.

# Summary of findings

People told us they had felt involved in making decisions about their care and treatment and felt listened to. They were treated with respect and dignity by the staff, and were spoken with and supported in a sensitive, respectful and professional manner. One person told us, “They respect my dignity and encourage my independence.” Peoples healthcare needs were monitored and they had access to health care professionals when they needed to.

People’s nutritional needs had been assessed and had a selection of choices of dishes to select from at each meal. Staff told us that an individual’s dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences.

People had the opportunity to attend residents meetings, they and their representatives were asked to complete a satisfaction questionnaire at the end of their stay. One person commented recently, ‘The staff are considerate and dedicated, and the catering service is good. Medication was provided on time.’We could see people were able to comment on and be involved with the service provided to influence service delivery. The registered manager told us that senior staff carried out a range of internal audits, and records we looked at confirmed this. The registered manager also told us that they operated an 'open door policy' so people living in the service, staff and visitors could discuss any issues they may have.

# Summary of findings

## 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.

Procedures were in place to ensure the safe administration of medicines.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed.

There were sufficient staff numbers to meet people's personal care needs. People were cared for by staff who had been recruited through safe procedures.

**Is the service effective?**

Good

The service was effective. Staff were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware people had to consent to their care and treatment, who had a DoLS agreed and in place and the care and support they needed as part of this agreement.

Staff had a good understanding of peoples care and support needs. People were supported by staff that had the necessary skills and knowledge.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. People had access to health care professionals when they needed.

**Is the service caring?**

Good

The service was caring. Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

**Is the service responsive?**

Requires improvement

The service was not consistently responsive. There were limited opportunities for people to participate in recreational activities.

People had been assessed and their care and support needs identified. Care and support plans were in place to ensure that care was provided in a constant way.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

# Summary of findings

**Is the service well-led?**

Good

The service was well led. Quality assurance was used to monitor to help improve standards of service delivery.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of the service was approachable and very supportive.

People were able to comment on and be involved with the service provided to influence service delivery.

Systems were in place to ensure accidents and incidents were reported and acted upon.

# Brighton & Hove City Council - Wayfield Avenue Resource Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 11 November and 19 November 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who had experience of working in mental health services. Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we had received. This helped us to plan our inspection. We did not request the provider to complete on this occasion as we bought forward the inspection following an incident at the service. A Provider Information Return (PIR) on this occasion. 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 contacted received the local commissioning team and received information from the Clinical Commissioning Team (CCG). From this information, following our inspection, we also contacted a health care and a social care professional to ask them about their experiences of the service provided.

We spoke with the registered manager, the registered mental nurse (RMN), seven care staff, two housekeeping staff and a cook. We observed the care and support provided in the communal areas, observed two medicines rounds, and sat in on a handover between staff shifts. We spoke with seven people who were living in the service. We also spoke with a visiting psychiatrist.

We looked around the service in general including the communal areas, and some people's bedrooms. As part of our inspection we looked in detail at the care provided to six people, and we reviewed their care and support plans or their medicine administration. We looked at menus and records of meals provided, medicines administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and six staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

We last inspected this service on 14 January 2014 when the service was compliant with all the regulations we reviewed.

Good

# Is the service safe?

## Our findings

People told us they felt safe and were well treated in Wayfield Avenue.

To support people to be independent, risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. People had individual assessments of potential risks to their health and welfare and these or activities they were involved in to help them reach their agreed goals and move onto further accommodation. Individual risk assessments completed included falls, nutrition, pressure area care and manual handling which were reviewed regularly. Records we looked at confirmed this. Additionally where people needed specific support for example, if they had been identified at risk of attempting suicide a risk assessment had been completed to detail their care and support needs to minimise the risk. Staff told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed.

We looked around the building and we found the premises were well maintained. The environment was clean and spacious, which allowed people to move around freely without risk of harm. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. Staff were able to access a maintenance department for the servicing and maintenance of the building and equipment. Records we looked at confirmed that any faults were repaired promptly. Staff told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for help and support. Fire evacuation plans (PEEPS) were in place to give care staff information on the support people needed in the event of a fire.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen at the service in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to

safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

The RMN developed a detailed mental health care plan and risk assessment with clear guidance on how to manage certain behaviours specific to individual people, For example, where one person was at risk of suicide the risk assessment had identified the need for care staff to carry out regular monitoring checks of the person. For one person who displayed a high degree of agitation care staff were guided to display a consistent approach to reduce the agitation and encourage an activity such as reading a book. For another person who could exhibit anti-social behaviour their risk assessment guided care staff to encourage the person to return to their room to call down away from any further stimulation.

We looked at the management of medicines. Policies and procedures were in place for care staff to follow. Care staff were trained in the administration of medicines, and had undergone a competency check to ensure they were still following the agreed policies and procedures. Medicines were stored safely Medicine administration records (MAR) charts are the formal record of administration of medicine within a care setting and we found these had been fully completed. Medicines were stored correctly and there were

Good

# Is the service safe?

systems to manage medicine safely. Regular audits and stock checks were completed to ensure people received their medicines as prescribed. People who were able to could be supported to manage their own medicines through a risk management process. Where people took medicines on an 'as and when' basis (PRN) there was guidance in place for staff to follow to ensure this was administered correctly. Staff could tell how and when this medication should be given. Where people had topical creams applied the recording had been completed to evidence it had been applied and inform other care staff.

Staff told us how staffing was managed to make sure people were kept safe. There were five care staff and a 'Duty' member on the day. 'Duty' was normally covered by senior care staff. This person coordinated activity on the day and prepared for the transition to the next duty to take over. If there was a staff shortage expected or special duties anticipated this person would seek more staffing resources in advance. There was a relief pool of bank staff who could be called at short notice to help cover any vacant shifts, or agency staff could also be called on, and where possible staff were requested who had previously working in the service and had an understanding of how the service was run. A team of ancillary workers who covered administration, domestic duties, maintenance, and catering services supported all the care staff in the service.

A dependency tool was not used to help ensure that there were adequate staff planned to be on duty. Senior staff regularly worked in the service to keep up-to-date with peoples care and support needs which helped them check there were adequate staff on duty. However, the registered manager told us they were in discussion with the local Clinical Commissioning Group (CCG) as to an appropriate tool to assist them to demonstrate adequate staffing levels were maintained. Staff told us although at times it could be busy there was adequate staff on duty to meet people's care needs. They told us minimum staffing levels were maintained. They also spoke of good team spirit. People told us there were enough staff on duty to meet people's needs. On the day of our inspection there were sufficient staff on duty to meet people's needs. Staff had time to spend talking with people and supported them in an unrushed manner.

Senior staff had the support of the provider's human resources department when recruiting staff. They told us that all new staff had been through a robust recruitment procedure to meet the requirements of the provider's policies and procedures. Staff recruitment files we looked at demonstrated a safe recruitment process had been followed. We found records of an application form being completed, an interview and two written references and a criminal records check having been received.

Good

# Is the service effective?

## Our findings

People told us they felt the care was good, and the choice and food provided was very good. One person told us, “Food is beautiful. Compliments to the chef. We are spoilt here.”

Senior staff understood the principles of the Mental Capacity Act 2005 (MCA) and gave us examples of how they would follow appropriate procedures in practice. The MCA 2005 is a piece of legislation which provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make specific decisions for themselves. The registered manager also had the support of an onsite RMN, who provided guidance. They told us that if they had any concerns regarding a person’s ability to make a decision they had ensured appropriate capacity assessments were completed. Records we looked at confirmed this. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. Care staff told us they had not all completed formal training, but senior staff told us and records we looked at confirmed care staff had received support and guidance through training provided in the service by the RMN and in team meeting and training days. All had a good understanding of their responsibilities under the Act, and the need for people to consent to any care or treatment to be provided. We asked care staff what they did if a person did not want the care and support they were due to provide. One member staff told us, “They have to agree. If they don’t want to do it, they won’t do it.” Another member of staff told us they would return and try again later. Where possible there was people’s care and support plan that their consent had been agreed to the care provided.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receivethe care and treatment they need. The registered manager told us they were aware how to make an application, and talked with us about the six applications which were currently in place. They were able to talk with us about one person currently required an urgent assessment and the application was sent the day before the inspection. Senior care staff told us they had completed this training and all had a good understanding of what this meant for people to have a DoLS application agreed. Not all the care staff felt they had received formal training or guidance, but had an understanding of what a DoLS application was. However, we found from records we looked at this had been discussed at previous staff meetings and the staff training day. Where a DoLS had been agreed this had been documented in the care and support plan. Care staff were clear who had a DoLS application agreed, and if there were any actions they had to follow to support people where an application had been agreed. We observed care staff supporting on person on a DoLS on the day. This was undertaken in a supportive and caring way.

People’s nutritional needs were assessed and recorded, and people’s likes and dislikes had been discussed as part of the admissions process. Some people had food and fluid intake charts. We found records were accurately maintained to detail what people ate or drunk to fully inform the care staff and enable them to assess if people had adequate food and fluid during the day, to maintain their wellbeing. People’s weights were monitored regularly with people’s permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person’s weight.

The cook told us there was a rotating menu, which was based on people’s likes and dislikes. The cook was seen to talk with people and explained to them there would be some consultation soon about the new menu. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. There was variety of optional sweets on offer. There was also fresh fruit as a snack available with meal times. Three people had their own menus following a discussion with the cook to meet their own individual needs. The cook showed us they had information available on the dietary requirements and likes and dislikes of each person. For example, This showed us that staff were aware of individual’s preferences, needs and nutritional requirements. People could also be supported to prepare and cook their own meals ready for their return home.

People spoke well of the food provided and staff came in advance on the day to ask them what they would like to eat. This information was then fed back to the cook. There were several dining areas in the building and people were able to opt for a preference of location for meals. The staff had a good knowledge and expectations for which people would be where and their food preferences and choices. We observed the lunchtime experience for people. It was relaxed and people were considerately supported to move

Good

# Is the service effective?

to the dining areas. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation.

People were supported by care staff that had the knowledge and skills to carry out their roles and meet individual peoples care and support needs. The registered manager told us all care staff completed an induction before they supported people. This had recently been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. New members of the care staff told us they had recently been on an induction. This had provided them with all the information and support they needed when moving into a new job role. One member of staff spoke highly of their induction and told us, "I really like it here and it is what I had wanted to do for years. I like working with mental health clients and there is great a variety of experience to encounter here. No two days are the same and it is really interesting." At induction they had shadowed for the first week and this was coupled with a wide range of preparatory training supplied by the provider. There was also a range of training that could be accessed on-line by all staff.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people. Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Training records viewed highlighted care staff had completed this training. Staff had also received training and guidance from the RMN on providing care and support to people with mental health needs. Additionally there were courses on personality disorder, alcohol and substance misuse, depression and understanding people with suicidal tendencies which a number of staff had attended. For example the registered manager, two senior staff and thirty percent of the care staff had attended the course on understanding people with suicidal tendencies to give them a greater understanding of how to support people. One member of staff told us the RMN provided training in the service, and," This is really helpful as we can relate to our clients." Staff were being supported to complete a professional qualification, for example one person told us they were working towards a Diploma in Health and Social Care.

One person who had been in the service for a number of years told us, "This is one of the best places I have stayed. The best thing about the staff was their good communication. Everything is clearly explained, even if they say 'no' it is easy to accept because of the clear explanations given." Staff told us that the team worked well together and that communication was good. Staff told us they had received supervision from their manager, they felt well supported and could always go to a senior member of staff for support. Senior staff told us they provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance and for senior staff to confirm care staff had attendee all their training and identify any further training or support they required. There was a supervision and appraisal plan in place which the senior staff were following to ensure staff had regular supervision and appraisal. Periodic staff meetings had been held. Records we looked at confirmed this.

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. The RMN told us that all the people retained a care coordinator from the local mental health team, although she herself became de facto the person who coordinated mental health care in the home. Feedback from the healthcare professionals we spoke with supported this. Care staff told us that they knew the people well and if they found a person was poorly they should report this to the manager. People were supported to maintain good health and received ongoing healthcare support.

Good

# Is the service caring?

## Our findings

People told us people were treated with kindness and compassion in their day-to-day care. They told us they were satisfied with the care and support they received. They were happy and liked the staff. During our inspection we observed people and staff in the communal areas. People were seen to be comfortable with staff and frequently engaged in friendly conversation. This was particularly apparent in the preparation and interaction during the time of discharge of one person who had been resident in the home for a number of years. Many of the staff on duty made an effort at some point to bid farewell to the person.

People were involved in making decisions about their care wherever possible. People were listened to and enabled to make choices about their care and treatment. Staff ensured they asked people if they were happy to have any care or support provided. For example, we observed staff supporting people. They were supporting people to improve their skills and reach their goals for more independence. Staff provided care in a kind, compassionate and sensitive way. They answered questions, gave explanations and offered reassurance to people. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listening to people, and there was a close and supportive relationship between them.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met peoples individual needs. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it affected them today. Care staff demonstrated they were knowledgeable about people's likes, dislikes. Staff spoke positively about the standard of care provided and the approach of the staff working in the service.

People told us care staff ensured their privacy and dignity was considered when personal care was provided. The registered manager was a privacy dignity champion. They regularly attended the support group meetings for dignity champions held in the city. They brought back information for the staff team. They talked with staff using scenarios with staff to promote and inform their understanding of dignity. Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they how protected people's dignity and treated them with respect.

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity.People had their own bedroom and ensuite facility for comfort and privacy. People were encouraged to treat the service as their home for the period of their stay. They had been able to bring in small items from home to make their stay more comfortable such as small pictures. People had been supported and encouraged to keep in contact with their family and friends, and told us there was flexible visiting. People were able to use the public phones sited in the service and there was internet access provided. People had been supported when making decisions about their care from staff from an advocacy service. Senior staff were able to confirm they knew how support people and had information on how to access an advocacy service should people require this service.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Requires improvement

# Is the service responsive?

## Our findings

People told us they were asked for their views about the service. They said they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. However, we found areas that needed to be improved upon.

There were limited formalised activities provided for people to join in. There was a daycentre adjoining the service which people could attend if there was a vacancy. There was a bus available to go out on trips, although this tended to be prioritised to the day centre. Care staff were aware of the importance of providing meaningful activities for people to join in. They told us they found it could be difficult to encourage people to participate in activities when they were arranged. We discussed this with the registered manager who acknowledged this was an area for improvement. They told us people had access to a smoking room on the ground floor. There were plans to convert this to an activity room and a smoking shelter had been built outside in preparation for this imminent change. We could see from minutes of the residents meeting these plans had been discussed as well as asking for ideas for activities people could join in. We could see that film nights and activities such as board games had been facilitated. People had also been out with staff to use the local facilities. This is an area that needs to be improved.

Senior staff told us everyone received a comprehensive assessment undertaken by the RMN or senior staff. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. If they felt they did not have enough information to make a decision they requested further information. Records we looked at confirmed this. Care staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. Care and support plans were compiled and inputted into by health and social care staff and contained instructions about the care and support needs of the individual. People were treated and spoken about as unique individuals. This was the followed through in the care plans. There was particular reference to 'Life Mapping' giving particulars of the person's history and likes and dislikes. There was detail of a person's individual goals, their communication, nutrition, and mobility needs. There were instructions for care staff on how to provide support tailored and specific to the needs of each person. Where people had been on observations we found that these had been fully completed to inform the care staff of the care that had been provided. These had been reviewed. One member of staff told us, "No two days are the same and I look forward to coming to work."

The RMN had access to the Trust computerised patient records system, and used all the information to complete a mental health care plan for each person to provide further information to care staff on peoples care and support needs. Feedback from the healthcare professionals was good. They told us staff were very caring and worked well with behaviour that challenges and were excellent at preventing admission to psychiatric hospital. Staff were willing to learn and change practice as and when advised to do so by the mental health team.

Staff told us that communication throughout the service was usually good and included comprehensive handovers at the beginning of each shift which they used to update themselves on the care and support to be provided. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. Staff told us they knew what people's current care needs were and received verbal updates from each other when people's needs changed and read about them in people's daily records. We asked the manager and staff how relevant information about people's care was communicated to staff coming on duty. We were told a handover took place between every shift to ensure continuity of care. There was a shift plan in place which described tasks that needed to be undertaken either 'am' or' pm' and also recorded the staff member allocated to complete it. Feedback form the health and social care professionals was that guidance they had given as to the care provided had been actioned and followed through.

People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans, by attending residents meetings and by completing quality assurance questionnaires. There was information in the service to inform people of how their ideas had been used to make improvements in the service. For example some a pool table had been purchased following a request.

People told us they felt it was an environment they could raise any concerns. One person was complimentary of the manager and the staff and told us, "She (the manager)

Requires improvement

# Is the service responsive?

always investigates quickly when there is a problem brought to her attention. She will come and inspect something in person". They also told us "The staff know the type of high performance that is expected of them, and that is has not always been the case in other places I have stayed." We looked at how people's concerns, comments and complaints were encouraged and responded to. People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which was available in people's bedrooms. No one we spoke with had raised any concerns. People told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. Where one concern had been raised this year, this had been recorded and responded to appropriately. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Good

# Is the service well-led?

## Our findings

People told us they felt the service was well led. Feedback from the health and social care professionals was that the service worked well and was well organised, staff engaged with them and there was a good working relationship.

There was a clear management structure with identified leadership roles. The registered manager was supported by a team of senior care staff. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided. Staff spoke highly of the registered manager who oversaw the day to day management of the service. Senior staff said she was, "Approachable and knows what was happening on a daily basis". Staff members told us they felt the service was well led and that they were well supported at work.

The aim of the service was to, 'Provide you with a comfortable, homely environment designed to suit your needs and choices of lifestyle. Staff are available 24 hours a day who will work closely with you to ensure that you are assisted to obtain your goals and desired lifestyle.' Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understood the importance of respecting people's privacy and dignity.

Staff meetings were held periodically throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service.

Senior staff carried out a range of internal audits, including care planning, checks that people were receiving the care they needed, progress in life skills towards independence, medication, health and safety and infection control. They were able to show us that following the audits any areas identified for improvement had been collated in to an action plan and how and when these had been addressed. The providers visited and audited the care provided. We looked at the last record of their visit which detailed they had looked at recording and the care provided. Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future. For example, falls was the highest proportion of incidents, and a themed audit on slips, trips and falls was carried out. The main reason for this was to try and establish if there are any common patterns or themes across the service with regards this type of incident and if there was anything staff can learn from investigating further, and therefore any best practise that could be shared.

The registered manager had periodically sent statistical information to the provider to keep them up-to-date with the service delivery. We looked at the last report which gave the provider information on staffing, incident and accidents, complaints and the maintenance of the premises. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run. The registered manager told us that where actions had been highlighted these had been included in the annual development plan for the service, and worked on to ensure the necessary improvements. The registered manager was able to attend regular management meetings with other managers of the provider's services. This was an opportunity to discuss changes to be implemented and share practice issues and discuss improvements within the service. For example they were due to meet to discuss the requirements under the Duty of Candour. The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. Policies and procedures were in place for staff to follow, and current guidance had been used to regularly update policies and procedures.