Papillon Care Limited

Conifer Lodge

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

The inspection took place on 4 July 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Conifer Lodge in April 2015, at which time the service was compliant with all regulatory standards and was rated Good. At this inspection the service remained Good.

Conifer Lodge is a single-story residential home in South Shields. It is registered to provide accommodation for up to 16 people who have personal care and nursing needs. There were 14 people living at Conifer Lodge at the time of our inspection.

The service had a registered manager in place. 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. The registered manager was on annual leave at the time of the inspection but there was a deputy manager in place.

People who used the service and their relatives told us staff helped keep them safe. Staff we spoke with had received safeguarding training and knew what to do should they have concerns about people's safety.

There were sufficient numbers of staff to meet people's needs in a safe manner and to maintain the premises. The building was clean throughout and undergoing refurbishment in communal areas. Since our last inspection a new communal/training kitchen had been installed.

There were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks. Nursing staff had their Nursing and Midwifery Council (NMC) status checked regularly.

A treatment room had been refurbished and the storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

Risk assessments with person-centred information were in place to manage the risks people faced. These were reviewed regularly and staff demonstrated a good awareness of them.

There was regular liaison with external healthcare professionals to ensure people received the care they needed.

Staff were trained in a range of core areas such as safeguarding, health and safety, moving and handling, fire safety, nutrition and dignity. Training needs were well planned and managed.

Staff received regular supervision and appraisal support from managerial and senior staff, as well as regular team meetings.

Feedback regarding meals was generally positive and we saw people who required specialised diets had their needs met.

Group activities included games, arts and crafts, outings to museums and the theatre, day trips to the coast, as well as holidays. Weekly activities were planned in consultation with people who used the service and the registered manager had recently recruited an activities co-ordinator.

The registered manager was meeting the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The atmosphere at the home was relaxed and welcoming. People who used the service, relatives and external stakeholders told us staff were friendly, patient and compassionate.

Person-centred care plans were in place and people and their relatives were involved in the review of care plans.

The service maintained good community links, with people who used the service feeling a part of the wider community in which they lived.

Staff, people who used the service, relatives and external professionals were generally positive about the registered manager and staff at all levels. The culture was one in which people's changing needs could be met and their preferences respected.

Quality assurance and auditing procedures were in place to ensure the registered manager and others identified where practice improvements could be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Conifer Lodge

Detailed findings

Background to this inspection

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

We visited the service on 4 July 2017 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one 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 service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

We reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

During the inspection we spent time speaking to people who used the service and observing interactions between staff and people who used the service. We spoke with seven people who used the service and one relative. One person who used the service did not want to speak with us. We spoke with seven members of staff: the deputy manager, the area manager, the administrator, the nurse in charge, two care staff and the cook.

We looked at four people's care plans, risk assessments, staff training and recruitment files, medicines information, a selection of the home's policies and procedures, IT systems, meeting minutes and maintenance records.

Following the inspection day we spoke with four more relatives, one external healthcare professional and one person's advocate.

Good

Is the service safe?

Our findings

We observed people were relaxed throughout the inspection, interacting with care staff in a trusting manner, for example when they were supported to take medicines. People who used the service consistently told us they felt safe at Conifer Lodge and had confidence in the ability and actions of staff should they have any concerns regarding their safety. One person told us, "It's dead canny, I have no problems here."

Relatives were similarly reassured, telling us, for example, "We've never had any problems. [Person] used to get into quite a bit of bother before going there but they have it under control." Another relative said, "The staff are very calming. There's never any major concerns." We observed staff appropriately de-escalating situations by asking people what they would like to do. For instance, making some food or going out for a walk to the local shops. Staff also gave people more personal space and time. When we reviewed people's care plans we saw these strategies were set out for staff as a means of reducing the risks people faced.

When a person began using the service risk assessments were put in place and included, for example, falls risk assessments, nutritional risk assessments and continence risk assessments. We saw the provider used recognised tools to help assess the level of risk people faced and then put in place care plans to help reduce these risks.

We reviewed people's medicines and saw a number of people were prescribed medicines 'as and when' required. We saw there was a clear protocol in place for when these medicines may be required and what impact staff could expect them to have. This was good practice. We saw two people were prescribed medicines to help cope with their anxieties and agitation. These were also supported by protocols, although these were not sufficiently detailed to describe what strategies staff members should use prior to administering the medicine. We reviewed the use of these medicines and found no evidence they had been administered inappropriately or over-relied on. We observed staff throughout the inspection demonstrating an awareness of people's needs and adhering to care plans that meant successful de-escalation strategies could be used rather than an over-reliance on medicines. During the inspection the provider ensured additional information to clarify for staff what strategies should be in place prior to the administration of PRN medicines was updated.

The storage, administration and disposal of medicines was generally safe and adhered to guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's individual records contained a recent photograph, allergy information and emergency contact details. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. Where topical medicines (creams) were prescribed we saw body maps were used to ensure people received the creams appropriately. Where new administration guidance was issued by the government regarding specific medicines we saw the registered manager shared this with nursing staff to establish whether it was relevant to people who used the service.

We saw the treatment room was tidy and kept locked when it was unoccupied. It had recently been renovated as the old treatment room was extremely small and lacked ventilation, meaning there was a risk

of the temperature rising above a safe limit. We saw room and fridge temperatures were regularly recorded in the new room to ensure they were within safe limits. This demonstrated people were not put at risk through the unsafe management of medicines, and that the provider had made changes where necessary to comply with relevant regulations.

When we spoke with external professionals such as nurses and commissioners, they raised no current concerns about the service. They stated, for example, "Generally speaking there are no problems with how people are cared for and how the service is run."

All staff we spoke with had been trained in safeguarding and were able to describe different types of abuses and how they could look out for the indicators of such abuse. Breakaway training and addiction training was taking place during the inspection visit, with a view to ensuring staff were well prepared to deal with a range of situations and keep people protected from harm. We found the registered manager encouraged a culture where concerns could be raised. Relatives we spoke with agreed this was the case. Where a serious incident had occurred, for example an altercation at the service, or a medicines error, we saw the registered manager had involved and notified the appropriate agencies.

We saw incidents and accidents were recorded and reviewed regularly to establish whether there were any patterns recurring.

We found there were sufficient staff on duty to meet the needs of people who used the service. We reviewed the rota and saw the usual levels of staffing consisted of one nurse in charge, one senior carer and two carers. People we spoke with were relaxed and content with the amount of support they received from staff, whilst relatives felt there were sufficient staff on duty whenever they visited. We observed the call bell system being used during our inspection and found staff responded to this promptly. Staff told us they felt ably supported and that there was sufficient staffing to meet people's needs. This meant people using the service were not put at risk due to understaffing.

We reviewed four staff records and saw pre-employment checks including references, identity checks and enhanced Disclosure and Barring Service checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw these checks were renewed every three years. Nursing staff were subject to monthly checks of their Nursing and Midwifery Council (NMC) registration to ensure there were no restrictions to their registration. This meant the service had a clear approach to vetting prospective members of staff and existing staff, reducing the risk of an unsuitable person being employed to work with vulnerable people

We found all areas of the building to be clean, bright and free from odours. We noted some drying plasterwork in the entrance hall as the provider was in the process of refurbishing the premises. At our last inspection we noted the communal kitchen area was in need of refurbishment. At this inspection we found it had been refurbished and was well maintained.

We saw the registered manager and area manager undertook regular checks of the environment and employed a handyman to repair any ongoing areas. We saw Portable Appliance Testing (PAT) had been undertaken, whilst all emergency systems, fire fighting equipment and lifting equipment had been serviced and tested recently. Water testing for legionella and E.coli had taken place. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

Personalised emergency evacuation plans (PEEPs) were in place and kept in the emergency grab-bag, which was regularly checked to ensure it was up to date. This meant members of the emergency services would be

better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

Staff training was well planned and managed. The administrator kept an individual record of courses staff had completed and needed to complete, whilst the provider's online system alerted the service when specific members of staff needed to refresh their training due to it lapsing. We found the system to be working well and staff to be well trained in a range of areas relevant to people's needs. For example, training as per the provider's induction procedures included safeguarding, moving and handling, fire safety, COSHH and Infection control. Additional training was also delivered, such as dementia awareness, equality and diversity, hydration and nutrition, mental capacity, infection control, medicines and managing behaviours that may challenge. We saw a number of these training courses had previously been refreshed every three years but the provider had recently decided to renew them annually. This demonstrated the registered manager ensured staff were trained appropriately to meet people's needs.

Relatives we spoke with told us they felt confident in the abilities of staff. One said, "The staff are excellent," whilst another said, "The staff know what they're doing." Visiting professionals were generally complimentary about the standard of information recording and sharing. For example, one professional told us, "They know the triggers and they put in place extra monitoring where it was needed." We saw feedback sheets completed by visitors contained similar feedback, such as, "I spoke with the senior involved in the lady's care. He was very knowledgeable – excellent care plans in place." We reviewed the systems used on a day-to-day basis to record and share information. For example, the daily notes records, handover books, and communication book. We found entries to be succinct and clear. This meant visiting healthcare professionals and colleagues on different shifts had up to date information available to them when starting shifts or visiting people.

Staff confirmed they had regular supervision and appraisal meetings and we saw evidence of this in personnel files. These discussions were in depth and gave staff the opportunity to discuss a range of issues, such as medicines management, training and record-keeping. Staff we spoke with valued these meetings and confirmed they received good levels of support, for example advice from peers and managers when they were undertaking vocational qualifications. Supervisions were planned well in advance and were conducted by nursing, care and managerial staff. We also saw evidence of regular staff meetings, at which topics such as training updates, activities, employee of the month and policy of the month were discussed.

We saw there was a varied menu with options at every meal. The cook displayed a good knowledge of people's preferences and specialised dietary requirements. We saw there were jugs of refreshments in communal areas, whilst people were actively encouraged to make their own drinks in the communal kitchen. At our last inspection we noted this area of the building required some refurbishment and, on this inspection, we found this work had been completed.

People's preferences were sought at monthly meetings whereby they could request different meal options to go on the menu. People we spoke with also confirmed if they didn't like something they had chosen, the cook was able to make them an alternative. People were generally complimentary about the range of food available and the standard of cooking.

We saw people were regularly weighed to protect them against the risk of malnutrition and staff used the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We found one instance where record keeping should have been clearer, although appropriate actions had been taken when the person's weight dropped, for instance referral to a dietitian and the introduction of fortified food supplements. The deputy manager explained the service was in the process of updating the documentation they used to record MUST information to ensure it was as clear as possible.

The premises were appropriate for the needs of people who used the service. Bedrooms were along two spacious and well-lit corridors adjoining the central living and dining spaces, whilst people made good use of the communal kitchen, making their own drinks and snacks. A smoking shelter had recently been built outside rather than the use of an internal room, meaning there was no smell of smoke in the service. We saw the provider was in the process of refurbishing he entrance lobby and, whilst the cushions on the sofas in one lounge were in need of replacement, the fabric of the building and fixtures and fittings were generally in good condition.

Staff consistently incorporated advice from external professionals into people's care planning and delivery to ensure their needs were met. People received care from a range of external healthcare professionals when needed, such as specialist nurses, GPs and chiropody.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The area manager and deputy manager demonstrated a good understanding of mental capacity issues, whilst one person's advocate told us "They understand how to support their best interests. They follow the process properly". We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

Good

Is the service caring?

Our findings

People who used the service were at ease throughout the inspection, interacting in a relaxed fashion with staff they had clearly formed trusting relationships with. We observed staff at all levels engaging in conversations and jokes with people who used the service in a manner that demonstrated they were aware of people's individual personalities and preferences.

People who used the service were complimentary about staff, stating, for example, "I get on with the staff well – they're friendly," and "It's very good – the people who are in here and very lucky to be here."

When we spoke with relatives they were reassured by the caring attitudes of staff that they witnessed on visiting people. One told us, "The staff bend over backwards for her – they're great. She comes to visit me regularly but it's not long before she's asking when she'll be 'home' – that's how she sees it." Another told us, "I was there last night – I get on really well with the girls and so does [person]. It's one of the nicest places they've been. It's always friendly and it feels quite homely."

We found this description of homeliness was a consistent theme of feedback from external visitors, whether relatives or professionals. On our inspection we likewise found staff to be welcoming and the atmosphere to be homely and relaxed. For example, staff, with the agreement of people who used the service, had adopted a cat two years previously, and people told us they liked having the cat around. Similarly, people had been able to choose the décor in their own rooms and some people we spoke with displayed pride in their surroundings. People told us they felt at home, with one person saying, "It's like a big family." This meant, whilst providing nursing care to people who used the service, the registered manager had ensured the service retained a homely rather than clinical feel.

Whilst no one who used the service was on end of life care we saw people and their relatives had been asked about their preferences should their health deteriorate and that end of life care training was planned for staff.

We spoke with an advocate of a person who used the service, who gave positive feedback regarding the ability of staff to ensure the person's best interests were represented. This happened through a regular review of the person's mental capacity and involving those people who knew the person best in decisions. We also saw the registered manager had recently arranged for an advocate to deliver additional training to staff to ensure they were aware of the importance of advocacy and how it can ensure people's best interests were supported. The advocate told us, "There were more staff than I was expecting and they were keen to learn, interested and shared their experiences."

We saw external visitors had filled in feedback sheets and, of the five completed, all five stated the service had 'achieved' a caring atmosphere that upheld people's dignity. The forms contained little qualitative information and the area manager agreed there was potential to gather more comprehensive positive feedback by reviewing the use and content of these forms.

We found people received good levels of continuity of care from staff. A keyworker system was in place, meaning staff were expected to support specific people in the completion of regular tasks and then complete the corresponding documentation. Whilst there had been some recent turnover of staffing we found people generally benefitted from knowing the staff who supported them well.

With regard to people's dignity, we found staff treated people with respect, for instance knocking on doors and awaiting a response before entering. Care plans were sufficiently detailed to ensure people's personal care needs were appropriately met in line with their wishes. For instance, where one person with short-term memory loss struggled to retain information we saw staff regularly repeated what they were going to support the person with to ensure they remained involved and free from anxiety.

People who used the service were involved in the day-to-day upkeep of the home, for example, tidying their room or doing the laundry. When we spoke with relatives about people's levels of independence, one relative said, "He didn't get involved in doing much before but staff are good at encouraging him and it's for his own good to be able to do these things." Another told us, "They've helped her have a bit more independence." This meant the registered manager ensured the culture of the service was focussed on supporting people to maintain their independence as far as they were able.

Good

Is the service responsive?

Our findings

We found people who used the service were supported to engage in activities meaningful to them and that their changing needs and preferences were well met. During our inspection we observed a number of people being supported to visit local shops and services. Some people went out a number of times and it was clear they were able to exercise choice.

The service previously had a dedicated activities co-ordinator in place but more recently had not. We saw the registered manager had recently recruited to this role again. In a management review two months previously we saw they had noted a slight downturn in the range of activities on offer and felt more structure was needed to the planning of activities. This demonstrated the provider responded proactively to the need to plan the options available to people and ensure their preferences were met.

We saw people had access to a wide range of recreational activities and that every Monday staff would write the week's activities on a whiteboard, in consultation with people who used the service. For example, some people planned to go to a library later to use their IT facilities. Other recent activities included a barbecue, day tips to the theatre and museums, watching lawn bowls and arts and crafts. People who used the service confirmed they enjoyed the range of activities and opportunities available and said, for example, "I don't get bored here." One person had wanted to camp in a tent and we saw staff had acquired a tent and set it up in the garden for the person. We also saw longer-term plans were made by people who used the service, for example to go on holiday later in the summer. We saw previous holidays had proved successful, with photographs of day trips celebrated in the monthly newsletters and on a wall in a communal area.

We found care planning and provision of care to be person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. People had contributed to 'life history' documents in care files, which gave staff a good level of information regarding what and who was important to them. People's individual interests, preferences, as well as their anxieties were taken account of. We saw each care plan contained a detailed pre-assessment of people's needs and care plans that were linked to the relevant potential risks. Positive reinforcement was built into care planning, for example praising people when completing new daily tasks. Instructions to staff were with people's personalities in mind, for example, "Make all points simply and avoid complicated words and jargon – speak in a warm, friendly manner at all times."

There was no formal planning strategy in place for each person to help them identify goals and then chart progress towards those goals. The registered manager in the Provider Information Return document stated they hoped to have this in place in the coming year, whilst the area manager confirmed this was an area that would help ensure the service remained focussed on people's individual goals.

Notwithstanding that, we found people had achieved good outcomes with the support of staff, particularly with regard to lessening the risk of social isolation. We also saw there was structure to how people were supported to improve their independence. For example, there was a skills calendar in the training kitchen which set out who would be working on which domestic skills on which day. People who used the service

had also recently completed DVD training on fire safety and the registered manager told us in the pre-inspection information that they planned to source more training for people. This meant people who used the service did have a structure to help them learn new skills. One relative told us, "He's come a long way with their help. He's mixing well and doing things he never used to do. He's been to discos and gets on with people now. He was self-neglecting a lot but they've given him help and a structure." Another relative said, "He didn't get involved in any activities before but they seem to know who to support him." This demonstrated, whilst the service did not use a recognised goal-orientated tool to support people to develop their own skills, staff supported people to achieve good health and social outcomes.

Care files were comprehensive and contained up to date, accurate information. Files contained a recent photograph of people and stated who their keyworker was. We found this system to be working well, with the relevant staff showing a good knowledge of people's needs. We saw care plans were reviewed regularly. Relatives we spoke with confirmed they were regularly involved in people's care planning and were updated if there were changes in people's condition. One relative told us they were more confident in approaching a social worker in the first instance regarding any changes to their relative's needs. The consensus of people we spoke with and their relatives however was a positive one regarding the ability of staff and management to identify and respond to changing needs appropriately. One external professional stated that the provider was not always quick to keep them updated regarding changes to people's needs last year but that there had been no issues since and that, generally, they found the service to be responsive to people's needs. We saw evidence of external advice being sought and this being incorporated into care planning to ensure people's changing needs were met.

No one we spoke with had had to raise a complaint but knew how they could do so. The consensus among relatives and professionals was that staff at all levels were responsive to concerns and would endeavour to find appropriate resolutions.

Good

Is the service well-led?

Our findings

The registered manager had been in post for two years and had extensive relevant experience, having previously been the clinical lead at the service. Whilst they were on annual leave at the time of our inspection, we found deputising staff and all processes and systems to be well organised. The deputy manager also had extensive relevant experience in caring for people with mental health needs. We found there was a supportive team in place, with the administrator helping to ensure the office was extremely well organised. All documentation we requested and viewed was accessible and accurate, whilst appropriate notifications had been made to CQC. Systems were in place to ensure the provider continued to remain compliant with its regulatory responsibilities.

People who used the service were complimentary about all staff and we observed the deputy manager interacting well with people who used the service throughout the inspection. They demonstrated a comprehensive understanding of people's needs, backgrounds, likes and dislikes. The majority of relatives we spoke with confirmed they had confidence in the management of the service, stating, for example, "You can go to them with anything and they listen," and, "They don't hide anything – it's always open and if anything crops up they let us know." One person's advocate we spoke with confirmed the registered manager had set aside specific time to see one person who used the service each day, as it was something that had lessened their anxieties. They said, "They make time for people, as much as is possible." This demonstrated the registered manager played an active role in meeting people's needs.

Staff we spoke with described the registered manager as, "Supportive," "Approachable" and, "Always available if we need any help or advice." We found morale to be high and there to be a strong team ethic.

We saw the registered manager held monthly staff and community meetings, the latter being an opportunity for all people who used the service to attend a formal meeting to discuss aspects of the service, such as meals, activities and staffing. We noted there had not been a relatives meeting in 2017. The deputy manager acknowledged these had not happened recently but that they planned to reintroduce them. When we spoke with relatives however they gave uniformly positive feedback about how the service involved them in people's care and sought their views regularly.

Good community links had been made and people who used the service felt comfortable visiting local shops, a gym and a community centre, where the service held events. We found the culture of the service to be outward looking in terms of community involvement, with a number of people regularly accessing the community with support from staff.

We spoke with the area manager. They also had a specialism in mental health needs and displayed a good working knowledge of people's individual needs, as well as a good knowledge of staffing, care planning and the ongoing service action plan. This was informed by the monthly audits completed by the registered manager, so that they and the registered manager had an agreed document charting where improvements had been made and where there were still outstanding actions. For example, we saw the area manager's audits had identified a number of minor medicines errors and that they had asked the registered manager

to undertake their own audit and review. We saw this had happened and found improvements had been made to medicines administration.

The provider had recently sent out surveys as a means of gathering routine feedback about the service. Although only one had been returned so far from a relative, the feedback was uniformly positive.

The registered manager had completed a range of regular audits, including medicines, kitchen, fire safety and care files. In addition to these we saw the provider also ensured a lay visitor attended the home on an annual basis to complete a 'Reviewing the Resident Experience' report. This described the atmosphere, décor of the home and interactions observed with people who used the service, as well as conversations with them and staff. This report was shared with the board, meaning the provider had in place a range of means to ensure the service remained accountable and any areas of service improvement that were required could be identified.

The deputy manager and area manager described a good working relationship with the local authority commissioning team and external professionals. When we spoke with these contacts they told us the service regularly involving and updated them and that they had confidence in the future direction of the service.

The area manager described plans to proactively share best practice across multiple locations in future, by identifying what had worked well at one service and use staff expertise to share this with other locations.

We saw staff had worked flexibly to cover all the necessary shifts to ensure the service did not need to rely on agency staff. This displayed the positive team spirit in action, which in turn ensured people who used the service received a continuity of care rather than receiving care from people new to them in the interim.

We found staff at all levels had successfully contributed to ensuring the culture at the service was person-centred and focussed on people's day-to-day choices, quality of life and independence.