The David Lewis Centre

Primrose Avenue - Crewe

Inspection report

30 Primrose Avenue, Haslington, Crewe, Cheshire, CW1 5NY
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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

Overall summary

The inspection was unannounced and took place on18 March and 29 May 2015. This location was last inspected in January 2014 when it was found to be compliant with all the regulations which applied to a service of this type.

Primrose Avenue is part of the David Lewis Centre which supports adults with complex needs to attain quality of life and to maximise their potential in a safe residential environment. The home is a detached house in a quiet residential area in the village of Haslington near Crewe. The house has four bedrooms each with en suite facilities and is part of the David Lewis "Community Programme".

The house draws on the rest of the David Lewis Centre for certain support arrangements most notably clinical, social work and administrative services. There were three people living in the home at the time of our inspection.

There is a registered manager at Primrose Avenue. 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.

We found that care was provided in an environment which was as homely as possible. Staff went to

Summary of findings

considerable lengths to make sure that people who lived there experienced it as their own home and undertook the same tasks and made the same choices as other people living in the community. Staff were informed about the need to safeguard people, were provided with right information they needed to do this, and knew what to do if they had a concern.

The home was well-decorated and maintained and adapted where required. People had their own bedrooms. Care was arranged with the needs of the people who used the service as the principal concern so that they had choices about their care and how they lived their lives. As well as community facilities people also had access to the specialist services available at the main David Lewis Site.

As part of the larger David Lewis Centre the home benefitted from being able to use many of the corporate systems which the main provider had developed. This meant that the home was well managed.

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. Staff knew how to help people to stay safe and what to do if they thought anything was wrong. They had access to good levels of information and risk assessments so that they would know how to respond to people's individual requirements.

There were sufficient staff to meet people's needs and their suitability was checked before they were employed. Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff were well trained and received a thorough induction when they started in the work. They received regular supervision.

Staff had a good awareness of issues of consent and the requirements of the Mental Capacity Act 2005. People had good access to health care both in the community and from the main David Lewis Centre.

Is the service caring?

Good

The service was caring because we saw that staff supported people in caring way. People had access to advocacy if they wished this and were encouraged to be as independent as they could be. In order to support and encourage this independence the home had been adapted where necessary.

Is the service responsive?

Good

The service was responsive because care planning was person-centred and so the service could be planned around individual needs and preferences. There were good arrangements in place for people when they moved into the home and again if they moved out. People had access to a range of activities including in the community.

Is the service well-led?

Good

The service was well-led because managers, supervisors and team members worked together to provide care that was centred on people's needs. Supervisory staff knew team members well and were to be seen around the care environment working alongside them.

There was a system of checks and audits in place to assure the quality of service provided. Each tier of the management and supervisory hierarchy played a role in making sure this happened.

Primrose Avenue - Crewe

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 was 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.

The inspection was unannounced on the first day and took place on 18 March and 29 May 2015. This location was last inspected in February 2014 when it was found to be compliant with all the regulations which applied to a service of this type.

The inspection was undertaken by two adult social care inspectors on the first day during which one inspector visited central departments on the David Lewis Centre site and the other visited the location. Both inspectors returned to the location to complete the inspection on 29 May 2015.

Before the inspection we checked with the local authority safeguarding and commissioning teams and the local branch of Healthwatch for any information they held about the service. We considered this together with any information held by the Care Quality Commission (CQC) such as notifications of important incidents or changes to registration.

During the inspection we talked with two of the people who used the service. People were not always able to communicate verbally with us but also expressed themselves in other ways such as by gesture or expression. We spoke with two of their relatives. We talked with three staff as well as the registered manager.

We looked at records including one care file as well as staff files and audit reports. We looked around the building and grounds used by the service.

Good

Is the service safe?

Our findings

When we talked with staff they demonstrated a good understanding of safeguarding principles and practices particularly as they might apply to the people who lived at Primrose Avenue. For example staff told us about how they made sure that where necessary people were provided one-to-one support when they went out which would mean they would be on hand if the person needed help such as because of a seizure.

Staff told us that they had received training in safeguarding as part of their induction and we saw from the current annual training plan that safeguarding training also formed part of the annual refresher training programme for supervisory, care, administrative and support staff.

There was a dedicated telephone line reserved for reporting safeguarding matters (including out of hours) which were dealt with by the social work department on the central David Lewis Centre site. Staff could contact this service direct and independently of their line management if they felt they needed to. Staff told us that they would report any concerns they had and that if they thought notice was not being taken then they would escalate their concerns to another agency. This is known as "whistleblowing".

We visited the social work department. Although there were no records of safeguarding incidents that related specifically to people who were living in the service we saw from other records that the system was robust. The social work department maintained regular contacts with the relevant local authority safeguarding teams.

We looked at care records and saw that they contained relevant documentation including comprehensive risk assessments and detailed person centred care plans that reflected the assessed need relating to the person's circumstances and their medical requirements. This meant that the service was able to provide care which took account of and where possible minimised risks to the person concerned.

We saw that the records contained detailed information relating to the management of the person's medical condition such as an epilepsy risk management record with a review of seizures and a medication plan. Where appropriate the in-house speech and language team were involved and any relevant choking risk assessments were undertaken. We saw records that indicated that people were weighed regularly so that any variations could be explained. We saw that the service utilised body maps to record injuries and falls assessments were kept for those people at risk.

Each house had team leaders one of whom was on duty at all times including at night. The remainder of the staffing was made up of care officers covering shifts between 7.30 am and 9.30 pm. The number of care officers could vary depending upon the needs of the people who used the service. For example on the second day of our inspection some of the people who lived in the home were away for the week and so care officer numbers had been reduced accordingly. We were told that the norm was for there to be one team leader and two care officers on duty in the day.

We saw that this was sufficient to meet the needs of the people who lived in the home. Staff told us they felt that staffing levels were adequate and were confident that they would be reviewed if required. We were told that the service could use bank staff employed across the David Lewis Centre organisation where necessary. One person had one-to-one support for periods of the week and staff told us that they were currently negotiating with another person's local authority for the funding to provide this for them.

Staff told us that because the house was some distance away from the main David Lewis Centre and was located in the community the usual response in a medical emergency would be to dial 999 and to use local hospital services. Since there was only one person on duty in the home at night this would mean that if a person was admitted to hospital they would have to do so unaccompanied by staff. Otherwise staff told us that they always had the backup of the staff at the main David Lewis Centre site who were available to give advice by telephone including in an emergency.

Given there was only one member of staff on duty at night we asked what arrangements were made in the event anything happened to this member of staff such as if they became ill. We were told that staff from other houses regularly made contact throughout the night to check on each other and that if there were any difficulties then they would alert the David Lewis Centre who would respond.

We saw that staff recruitment was managed centrally by the human resources department at the David Lewis Centre

Good

Is the service safe?

site. We visited the department and asked to see a selection of recruitment records including one which related to the workforce at Primrose Avenue. We checked to see if the provider took precautions to make sure that the staff who worked in the home were suitable to do so. We looked at staff files and saw that they included application forms from which the provider could check an applicant's employment history, references which had been checked with the person who supplied it, and records of interview. The provider obtained its own checks from the Disclosure and Barring Service (DBS). These checks help an employer to verify any criminal record and to take this into account when considering employment.

We saw that the registered provider undertook widespread recruitment campaigns but we were told that that the final selection interview was conducted by the registered manager with a residential manager and central human resources support. The registered provider monitored staff movements regularly and had a clear picture of staff recruitment requirements at any one time. We saw also that some staff were recruited to the community houses from other parts of the David Lewis Centre. This meant that specialist skills and knowledge were retained within the service.

We looked at the arrangements that were in place to make sure that medicines were managed safely. We saw that there was a system for making sure that required medicines were ordered from the local pharmacy in good time so that supplies would not run out. This is particularly important where medicines are required in order to control the incidence of seizures. Staff showed us how medicines were checked on delivery by two members of staff. A medicines administration record (MAR) was then completed by staff who both signed to certify that this had been done accurately.

Because of the importance of medicines being administered correctly we saw that the provider used a specially designed MAR sheet which separately recorded emergency medicines from others such as regular medicines, short course and once only treatments as well as medicines given PRN or "as required". We saw that there were protocols in place so that staff would know how and when to use PRN medicines.

The use of this form of MAR sheet was common across all parts of the David Lewis Centre and this meant that if staff worked in different parts of the service they were always familiar with the same format. We found that staff were well-informed about the medicines which were in use at this location. All staff had received training in the administration of emergency medicines with more senior staff trained in more complex administration. The staff could refer to staff such as the centre care nurses at the main David Lewis Centre site if they required additional advice.

We saw that all medicines were stored in a secure room and that the key to this room was kept on the person of a senior member of staff at all times. Within this room each person who used the service had a separate compartment containing their medicines which was labelled with their photograph so as to assist with clear identification. We saw that the MAR charts were correctly completed and were up to date.

Appropriate arrangements were in place for medicines to be checked out and back in again when a person left the premises. People who needed to take their medicines carried them in a pouch which had a security lock to prevent unauthorised tampering. If the medicine was used this was recorded and the pouch replenished on return and a new security lock attached. There were no controlled drugs in use at the location at the time of our inspection

Good

Is the service effective?

Our findings

Staff told us that they felt equipped to carry out their role and had access to training relevant to the work. One member of staff described the training they were provided with as "phenomenal". We saw that some staff held National Vocational Qualifications (NVQ) in health and social care at various levels. NVQ (and their replacement the Qualifications and Credit Framework) qualifications are competence-based which means that people learn practical, work-related tasks designed to help them develop the skills and knowledge to do their job effectively. We looked at training records which showed that training completion levels of better than 95% were being achieved across the locations managed by the registered provider. This meant that staff were trained to do their job and their training was being kept up to date.

When first employed by the provider staff were required to undertake a 17 day induction programme which was made up of a mixture of online and face to face methods. Induction training must be provided by employers within the first twelve weeks of employment to make sure that staff are ready to work with people in a particular setting and that they have the right skills they need to do the job.

Staff confirmed that they had received induction training when they first started employment with the registered provider. Training is provided as one of the central functions located on the David Lewis Centre site. We visited the training department and saw that the programme was made up of the key units of the common induction standards recommended by the employer-led workforce development body for adult social care in England.

Following induction new staff had to complete a six month probation period during which their performance had to be satisfactory. We saw that the probation review included a consideration whether standards had been met in respect of areas such as safety, safeguarding and person- centred care. Subsequently staff undertook refresher training to keep their knowledge and skills up to date. We saw from the training plan that this was extensive and tailored according to each worker's role.

Staff told us that they received regular supervision and we checked supervision records to confirm that this was the case. Formal supervision is a meeting that takes place in private with the immediate manager to discuss staff training needs and any issues of concern. We were told that this takes place at a minimum frequency of six times a year and we saw that records of these were kept in the home in a locked filing cabinet. An electronic system was used to monitor progress on this and to make sure that supervision was taking place as expected. We checked this system and saw that supervision was up to date and that most staff had also had an annual appraisal. The David Lewis Centre has a supervision policy which includes this location. We saw that these arrangements accorded with that policy.

When we spoke with staff we asked them how they made sure that people consented to the care which they were receiving. Staff displayed a good awareness of the need to obtain consent from people. They understood the need to take into account the different levels of mental capacity which people might have and how this might be related to the particular circumstances and context in which they were being asked to give this consent. Staff told us that they would sometimes explain something the day before so as to give the person time to think about what was proposed and they would then go through this explanation again. This meant that people would not be unfamiliar with what was being proposed and would have time to think about it and their response. Where appropriate staff said they would involve relatives so as to help explain something to a person.

We saw that the registered provider had used best interest assessments where there was doubt about a person's ability to make a certain decision for themselves. We saw that these had included in relation to vaccinations and for the management of finances. The registered provider had also provided one person with the opportunity to discuss their residency at Primrose Avenue and had used varied means of communication to allow the person to express their preference to continue living in the home.

Because of the different requirements of the people who used the service we saw that staff sometimes used pictorial means to communicate important information to people who used the service. Staff showed good familiarity with which methods would suit each person so that they could match this to their needs.

The Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS) makes provision for people who may not be able to make some decisions or give consent for themselves. Primrose Avenue is a care home for

Good

Is the service effective?

these purposes and must observe the requirements of this legislation. When we visited the main David Lewis Centre site we saw that the administration of DoLS applications was managed by the social work department.

We visited the department and saw that the provider was following the requirements in the DoLS. We saw that they had submitted applications to the relevant supervisory bodies and maintained systematic records so as to keep track of them once they were authorised. We looked at the paperwork for a sample of these and found them to be in order. Although at the time of our inspection there were no DoLS in place for the people living at Primrose Avenue we were confident that the provider understood its responsibilities in this regard and had robust arrangements to manage these.

We saw that there was evidence in the care records of mental capacity assessments being undertaken and reviewed by the provider. We saw that staff were actively assessing issues of mental capacity and were aware of what would be required including giving consideration as to whether an application for DoLS authorisation was currently required.

We saw from the annual training plan that training in mental capacity and DoLS was included in induction training for all care staff and was set to be refreshed at two yearly intervals. The provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act and the specific requirements of the DoLS. In each house there were DoLS guides, safeguarding team access details and other safety and procedure protocols visibly displayed in staff areas.

As well as being subject to seizures sometimes, people who lived in the service might behave in an unexpected way that could present a risk to themselves or to those around them. Staff explained to us that they sought to implement positive behaviour management utilising redirection and prompting if people became challenging. We saw that the service had a specialist challenging behaviours nurse who developed comprehensive care plans that were reviewed on at least an annual basis or at any point the person's behaviour changed significantly. There was a central reporting system for such incidents meaning that they could be easily reviewed by this specialist and appropriate recommendations made.

We looked at the arrangements for people to eat and drink at the home. There was a well-equipped domestic-style kitchen and we saw that each person who used the service was able to choose their own menu and then staff would support them to go shopping for what they required. Where appropriate menus were presented in a pictorial format. We saw that fresh fruit was readily available to people.

The people living at Primrose Avenue had access to local community health services such as GPs and dentists. People also had access to the full range of in-house health care services provided by the David Lewis Centre site. This provided them with most of the clinical services they required such as doctors, nurses, psychologists, occupational and speech and language therapists, physiotherapists, podiatrist, dentist and the dietician.

Good

Is the service caring?

Our findings

One relative told us that they were "very pleased" with the care provided by the staff at Primrose Avenue. They described their relative as a "different person" since going to live at the home and added "I've got my (relative) back. The staff let (my relative) do it their way – I am just so happy".

Another relative told us "I can't praise (the staff) enough – my relative has come on so much – I am really pleased with the service". They confirmed that they were kept informed about developments and were asked for their opinions and views and were involved in care plans

During our inspection we heard staff talking with people who used the service in way that was respectful and caring. When required we saw that staff were appropriately directive in a way that was firm but kind. We saw that care staff and the people who lived in the home related to each other in a relaxed and friendly way. Because we visited the service over two days with a gap in between we were able to see the progress that individual people had made since our first visit. This showed that care plans were being effective in helping people to achieve their desired goals. Care plans were reviewed at least six-weekly by a multi-disciplinary team.

All of the people who lived at Primrose Avenue had families and most had been assessed as having mental capacity. In one instance a family member had the legal authority from the Court of Protection to act on behalf of their relative. The service had involved an advocate on one occasion where another person had needed support but preferred not to involve their family. One person was continuing with advocacy support from a professional advocate who had been known to them prior to their admission to the home.

We saw that staff sought to help people to maximise their independence. For example at this location we saw that one person was being encouraged to learn to manage their medicines for themselves. We heard staff check out what assistance people needed before offering assistance for example when staff offered a person some fruit - "Can you peel this or do you want some help?" When a service user asked us to undertake something they could actually do for themselves staff gently reminded them of this.

We saw from other documentation that one person was beginning to manage their financial affairs for themselves by learning to use online banking and that another person made their own healthcare appointments with the doctor and dentist although they knew they could ask for staff support if they required this. We saw that people's families were encouraged to be involved in and consulted about their care wherever possible and that people who lived in the home were encouraged and supported to make overnight visits to family where this was possible.

We saw that because people had a diverse range of communication abilities the service used various means of communicating with people. We saw that these included pictorial methods such as to illustrate activities or menus. We saw that people who lived in the home could influence their care by discussion with staff. The "Listen to me" booklet gave people the opportunity to record a large number of preferences including likes and dislikes, important things and important people and how best to communicate with people depending on their mood. People could record their entries in this book either in words or in pictures or both. There were periodic meetings with all the people who lived in the home to discuss common issues.

Primrose Avenue is one of a number of properties provided for small groups of people to live in the community with more independence. Each location is registered separately with the Care Quality Commission. The property is owned by a registered social landlord and rented to the David Lewis Centre. This means that the responsibility for upkeep is shared between the housing provider and the David Lewis Centre. The people who live in the home are therefore not direct tenants of the social landlord. This limits the range of benefits that people can receive.

Although the registered social landlord undertakes redecoration at periodic intervals we were told that the David Lewis Centre will undertake additional redecoration as required and is also responsible for the furniture and fittings. We saw that the property was decorated inside and outside to a very high standard and that furnishings were homely and comfortable. This meant that the house blended in well with the community in which it was located and contributed to the privacy and dignity of the people who lived in it.

We saw that the physical environment of the building had been well adapted to allow people using wheelchairs to access the facilities. This included low work tops in the kitchen, and the provision of a wet room including a

Good

Is the service caring?

specialised bath. The main living area was uncluttered so as to facilitate wheelchair access and bedrooms were large. We saw people undertaking household chores such as helping in the laundry, cleaning their own bedrooms and going out to do household shopping. We asked one person if we could look in their bedroom and saw that they had personalised it as they wished so as to reflect their own interests. We saw that people were free to use the space provided within the house as they chose. One person returned to their bedroom after watching television in the lounge whilst another person came and went between their bedroom and the dining area so that they could chat to us.

The provider had made arrangements to implement a recognised care pathway for people when they were nearing the end of their life. The aim of this pathway was to ensure all people received high quality end of life care that encompassed the philosophy of palliative care. We saw that training in this pathway was included in the provider's training plan.

Good

Is the service responsive?

Our findings

We were able to look at the way that the service made arrangements to introduce people who were new to service. We saw that this included a transitional period during which the prospective new resident made a number of visits to the home. This gave the person the opportunity to try the home at various times including with an overnight stay and for staff to assess their needs prior to a final commitment being made on either side. We saw that the home included a transition log within its care files which was used to record information whenever a person was joining the service or making a transition between different parts of the David Lewis Centre or out to another service.

We looked at one set of care plans for a person who used the service and found that this contained the required information to meet the person's needs. We saw that these plans followed a pattern which is standardised across all the services provided by the David Lewis Centre and is called the "common care file". This was a paper based record and care planning system with records held in ring binder folders and neatly stored in a locked cupboard in a room upstairs. Because the cupboard was locked people could be reassured that their personal information was kept confidential.

We found that the file contained detailed daily logs so that staff could easily find what had been happening with people's care. This helped to provide continuity between different staff. There was a one page profile which is a means of helping a person to identify for staff key areas such as how they communicate, what they like to eat and drink, how they show if they are happy or sad, and as aspirations for the future. The file contained medical and other information which would be required to support the management of conditions such as epilepsy. We saw that the home included a transition log within its care files which was used to record information whenever a person was joining the service or making a transition between different parts of the David Lewis Centre or out to another service. Another section included risk assessments which had been reviewed.

We saw that senior staff maintained the records and updated the care plans on a monthly basis, with all other care staff using the daily report records within the notes to document a contemporaneous record of care. This was completed in the morning afternoon and also at night but additionally whenever something notable needed to be recorded. We were told that this home was about to start using a new online system of care recording which we had seen at another location and which appeared to offer opportunities for care information to be updated in real time and the information to become more readily available to care staff.

We found the care files to be stored correctly, neatly and tidily with contents sections clearly indexed and methodically arranged. The records included a "one page profile" of the person which illustrated a number of key elements such as likes and dislikes, hobbies and "things you need to know about me" plus communication strategies, danger awareness and "things important to me" elements. On this basis the care files would help staff to understand and respond to a person's individual needs. The use of pictorial records helped people who have communication difficulties to take part in and be involved in their own care plans.

The use of person-centred tools such as a "one page profile" meant that the service could be organised around the needs of the person rather than the requirements of the service. As well as encouraging and facilitating involvement this would help any new member of staff to learn a great deal about the person in a short period of time. All care records contained a recent photograph of the person so that any unfamiliar staff could recognise them. All the records we checked contained relevant assessments including comprehensive risk assessments.

We saw that people who lived at the home undertook a number of activities both at home, in the community and by visiting the main David Lewis Centre site. One person showed us their collection of videos and told us how they enjoyed watching their favourite pop star. Another person was purposefully watching television in the lounge. When the specific programme they were watching ended they left the lounge and the television was switched off rather than just left on.

We saw that people undertook chores in the house depending upon their abilities. People undertook shopping journeys into the local community as well as attending a social club and visits to the hydrotherapy pool. We saw that where required people were provided with a pictorial time line of their activities. We saw reports of some activities

Good

Is the service responsive?

which were shared between the people who lived in any of the three houses managed by the same residential manager. These included outings, barbeques and a Halloween party.

We saw that there was a complaints policy which was shared across the David Lewis Centre. This was very detailed and outlined the steps to be taken in the event of a complaint being made. The policy identified the importance of communication in the satisfactory resolution of complaints. We checked the complaints log at this location but none had been registered.

Good

Is the service well-led?

Our findings

There is a registered manager at this location. Primrose Avenue is one of seven similar properties which are managed by the same registered manager. The houses are then grouped under two residential managers although one of these posts was vacant at the time of our inspection. The current residential manager was therefore managing all the properties temporarily pending a new appointment.

We saw that the residential manager moved between the homes under her supervision and it was clear that she had a good knowledge of both the staff team and the people who lived in the home. This provided effective supervision and management and set a leadership style. This in turn meant that during our inspection we saw that staff took steps to make sure that people were involved in making decisions about the care they received. It was clear to us that staff worked as a team and that there was a relaxed and friendly atmosphere which extended across both the staff group and the people who lived in the home.

We saw that the staff and managers took a person-centred approach to providing care. Person-centred approaches help providers and their staff to find out what matters to a person so that they can take account of their choices and preferences. We saw that this was reinforced by the use of paperwork such as the "Listen to me" booklet which was used to help people to think about their life and plan how they were going to go forward.

Primrose Avenue is part of the David Lewis Centre which is a registered charity with a board of trustees. We saw that members of this board made regular site visits to all parts of the Centre including this location. Each was made by a different trustee each of whom carried distinct responsibilities. We looked at the most recent of these reports and saw that the visit had been overwhelmingly positive.

It was clear from the reports that we saw that during their visits the trustees took their responsibilities very seriously and wherever possible engaged with both the staff and the people who used the service. This meant that the board received regular information about the running of the service which was independent of the management or staff. No matters of serious concern had been identified in any of these reports. We were given a structure chart which included photographs of senior officers so that people who used the service could identify them.

We saw that the provider also undertook internal inspections. We saw that these were completed quarterly and were carried out by the residential manager. The reports were then sent to the registered manager and seen by the Chief Executive Officer (CEO). Any matters arising were raised with the appropriate manager.

We looked at the most recent of these monthly reports and found that it was comprehensive, detailed and clear on any requirements for corrective action. This confirmed that the registered provider was taking steps to monitor the quality of service provided. We saw that the CEO participated in the internal inspection process which meant that he maintained contact with the service being provided and also provided written team briefings as well as chairing meetings with staff.

We saw that there were other systems of audits or checking in place such as for complaints, staffing levels, fire safety, care plans and finance records. Each person in the management hierarchy had some responsibility for monitoring or auditing service quality. For example we were told that medicines audits were completed by night staff and we saw that team leaders undertook monthly audits and checks of care files. The registered manager completed service reviews and also visited the home as part of a fortnightly rolling programme of visits to all the homes she had responsibility for and also attended some of the multi-disciplinary meetings. This meant that she was able to monitor the quality of service at first hand.

The registered manager told us that she received monthly supervision from the CEO but felt that she could approach him at any other time if necessary and that she felt well-supported. There were also peer meetings between all the registered managers within the David Lewis Centre which she attended.

We saw evidence of forward planning for the service. For example, the registered provider had audited its training arrangements to confirm that they would incorporate all the standards for the forthcoming care certificate which is about to be introduced. The care certificate sets out explicitly the learning outcomes, competences and

Good

Is the service well-led?

standards of care that will be expected in the health and social care sectors and will be replace both the common induction standards and the national minimum training standards.