Waters Park House Limited

Waters Park House

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 of Waters Park House ("Waters Park") took place on the 12 and 13 March 2018 and was unannounced.

We last inspected Waters Park on the 2 and 3 February 2017. We had rated the service as Requires Improvement having found issues as to whether the service was safe, responsive and well-led. We found breaches of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we had not received all notifications as required and the leadership and governance of the service was not ensuring the quality of the service and people's records were not always accurate, complete or showing the complete story of people's care. Notifications are specific events registered persons have to tell us about.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the areas above to at least good.

On this inspection, we found the concerns from February 2017 had been addressed in full.

Waters Park is registered to provide care with nursing for up to 23 people. They support people who have experienced a brain injury or a diagnosis which impacts on the brain such as Huntington's or a stroke. People may have mental health, physical disabilities or a sensory impairment due to the impact of their condition.

Waters Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in place to manage and oversee the running of 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 registered manager was also the provider. They were supported in their role by a care manager, a nurse manager and a multi-disciplinary team (MDT). The MDT was made up of qualified nurses, occupational therapists, a physiotherapist, a psychologist, a speech and language therapist and rehabilitation assistants.

Following the last inspection the MDT had worked hard to address the concerns. The MDT were passionate about the needs of people and supporting them to reach their potential in life. This support and caring included the family and friends. People were supported to communicate in their chosen way and every effort was made to ensure this happened. Staff also made sure they understood people well so any concerns could be picked up and resolved quickly.

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.

People received effective care from staff who had the skills and knowledge to meet their needs. Staff monitored people's health and well-being and made sure they had access to other healthcare professionals according to their individual needs. People had their medicines administered safely. Errors were picked up quickly and action taken to keep people safe. This was one example of how the service demonstrated they learned from events

The service was responsive to people's needs and they were able to make choices about their day to day routines. People had access to a range of activities which provided them with mental and social stimulation. People's faith and cultural needs were met. People could access the community safely.

People felt safe at the home and with the staff who supported them. There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. There were adequate numbers of staff available to meet people's needs in a timely manner. Staff were recruited safely.

People could be confident that at the end of their lives they would be cared for with kindness and compassion and their comfort would be maintained. The staff worked with other organisations to make sure high standards of care were provided and people received the support and treatment they wished for at the end of their lives.

People said they would be comfortable to make a complaint and were confident action would be taken to address their concerns. The registered manager and provider treated complaints as an opportunity to learn and improve.

The home was well led by an experienced registered manager and management team. The provider had systems in place to monitor the quality of the service, seek people's views and make on-going improvements. Safe infection control practices were followed.

Further information is in the detailed findings below.

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 now safe.

This was because people now had risk assessments in place so staff could manage any risks.

Is the service effective?

Good

The service continued to be effective.

Is the service caring?

Good

The service continued to be caring.

Is the service responsive?

Good

The service was now responsive.

This was because peoples' care records had been improved to ensure they contained the information required for staff to give personalised care. A care plan audit was now in place as well.

Is the service well-led?

Good

The service was now well-led.

This was because robust quality assurance processes had been implemented.

CQC had been provided with all relevant information as required.

Waters Park House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 comprehensive inspection took place on the 12 and 13 March 2018 and was unannounced.

The inspection team included one inspector, one specialist nurse and one expert-by-experience. The expert-by-experience was a person who had personal experience of using this type of care service.

Prior to the inspection we gathered information about the service. We checked we had been receiving all the correct notifications. Notifications are specific incidents registered persons have to tell us about. We also checked the provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people and two relatives. Some people were unable to verbally communicate. Staff and family helped us communicate with people so they could tell us their experience by using the person's unique communication method. We spoke with eight staff from the multi-disciplinary team (MDT) and were supported on the inspection by the care manager, nurse manager and registered manager.

We looked at the care records of six people in detail, spoke with them and observed how staff interacted with them, where we could. This was to make sure they were receiving their care as planned. We also looked at the records held by the service to measure the quality of the service and the safety of the equipment and premises.

After the inspection family and visitors were sent a questionnaire for their feedback. We received two of these back. We also asked for feedback from health and social care services involved with people living at the service. We heard back from one GP.

Good

Is the service safe?

Our findings

At our last inspection in February 2017 we rated this key question as Requires improvement. Improvements were needed to ensure staff had a way of knowing people's risk and how to mitigate them. Where risk assessments were in place these did not always reflect the current level of risk. This meant staff did not have information, within records, to help them understand which risks to prioritise. Other risks associated with people's medicines, smoking and diabetes had not been assessed.

On this inspection we found the previous concerns had been addressed. This key question has now been rated as Good.

Since the last inspection, people's risk assessments had been reviewed and rewritten. People's records of their risks were clearly recorded and where possible people, their advocate and/or family were involved in agreeing and reviewing these. The MDT discussed people's needs formally on a weekly basis. The members of this team wrote the risk assessments using their expertise and outside professionals were involved as needed. For example, Drug and Alcohol services, GP, dietician, specialist Consultants (Endocrinologist, Neurologist, and Psychiatrist) and specialist nurses were asked to give their view. Staff received specific guidance and support to manage any risks. This meant people could live as free of restriction as possible or support was put in place to ensure this. For example, people had two staff to keep them and others safe if this was required. A GP told us, "Patients seem to be well monitored and appropriate precautions taken in respect to individual risk".

People, family and staff confirmed risks could be reviewed at any time with people. People also confirmed that they felt the level of support from staff allowed them to feel confident in themselves using the community again. People were supported to re learn life skills such as identifying risks in others, using a bus safely and looking after their money when they went shopping. This enabled them to become more independent and safer in the community. For example, one person told us, "I go out on my own to the park [now]". People were assisted to communicate their needs in line with their communication method which could include electronic devices, hand signs and blink methods of understanding each other.

One person told us, "Yes, I feel safe living here" and another, "I'm safe here". A family member said, "Yes, (my loved one) is safe; all the staff know his needs and make sure he is safe."

Staff received training in keeping people safe from abuse and harassment. Action was always taken in respect of any concerns and the service worked closely with advocates, CQC and the local authority if there were any issues. Staff were aware of the potential for abuse due to the high vulnerability of the people they were supporting. For example, staff were aware of the risk of exploitation. Staff described how they supported people when concerns were raised and this was reflected in people's records.

Another relative said, "Yes, my relative has never been safer, he is unable to look after himself and having so many caring professionals providing his care package has put our family's minds at rest".

People, family and staff told us they felt there were enough staff. We found there were adequate numbers of staff during the inspection to keep people safe. Staff were visible in the communal areas and interacted with people. People had the number of staff available to meet their needs as described in their care plan. This could mean that staff worked on a one to one basis with some people, or two staff would go out into the community or to appointments with some people, if required. For those people who could use a call bell or ask for support from staff, this was achieved quickly. Staff worked together and were aware of people's needs if they could not ask. This meant people had their needs met in a timely fashion.

A family member said, "Staffing levels always seem adequate to me, however I am sure they could always use more staff resources." Another family member said the weekends could be lower staffed sometimes but all care was given. It meant there were less staff to support social activities, for example. The registered manager advised there have been times in recent weeks when staffing has been affected by the flu virus. They told us, and staff confirmed, that all staff would work together and management would help out to make sure people's needs were met.

Staff were recruited safely and all the required checks were in place before starting to work. Staff completed a probationary period during which there were regular "check-in" sessions with and observations by senior staff. Staff were confirmed in their role permanently only when it was felt they had the right values and aptitude for the post. Action was taken at any time in respect of staff practice should there be a concern.

People received their medicines safely from registered nurses and care staff who had received specific training to safely carry out this task. All staff who administered medicines had their competency assessed on a regular basis to make sure their practice remained safe and in accordance with the provider's policies and procedures. People received their medicines as prescribed and had regular medicine checks with their GP to ensure they were on the right medicine to meet their needs. For example, as people recovered from their brain injury, and were undergoing a period of rehabilitation at Waters Park, their medicine needs could change often. Getting this right for them would enable them to regain control of their life.

The service demonstrated many opportunities when they had taken the opportunity to learn and improve the service as a whole. The safe administration of medicines was assured due to a thorough system of auditing and staff feeling errors could be reported with the expectation support would be the response. A recent audit identified two medicines had gone missing; the service reported this to us and the other relevant authorities and these medicines were placed under tighter controls. Staff were given protected time to order, book in, administer and audit medicines. They wore red aprons when doing this as this had been decided, by staff and people working together, as the safest way to do this so they were not interrupted. People confirmed they were not to interrupt staff in the red aprons.

People were protected from the risks associated with infections. Staff had regular training and clear policies were in place to keep people safe. The kitchen, laundry and home were kept clean and free of adverse smells. Staff were trained and understood the need to keep people safe. They were aware of the vulnerability of some of the people to infection and worked to practice good infection control. For example, for people being fed through the stomach wall, using a catheter or having a tracheotomy in place. Staff were trained to maintain equipment to keep people safe. For example, suction machines were kept clean and ready for people who may need them. An audit was completed every six months to check the system of infection control was in line with the provider's policy and current guidance. A family member said, "Staff appear to conform to infection control best practice as far as I have witnessed".

Good

Is the service effective?

Our findings

The service continued to be effective.

People were looked after by a range of staff with different skills. Each staff member had training to support their role. Those staff with a professional registration told us they had all the training needed to maintain their role within the home and to ensure their ongoing professional development. Staff also had the required support to understand their role with those needing it having both time with management and an external supervisor to ensure their ongoing refection on their work for people. Staff new to the service did not undergo the Care Certificate; instead they underwent the Waters Park specific induction and were immediately entered on higher qualifications in care. This meant all staff at Waters Park either had their own professional qualification or were at least working towards a Diploma in care.

Staff told us that any training was reviewed and they could ask to attend training they felt was relevant to their work. They were not allowed to perform complex procedures until trained and signed off as competent. There was good multi-disciplinary working where best practice was shared.

Staff told us there was a clear and comprehensive handover at the start of each shift. Staff checked an agency nurse was able to perform the complex nursing procedures required for some people. There was also a helpful 'at a glance' checklist, that briefed staff on each person's particular up to date requirements, risks and status.

People and families said that staff were trained well and they felt confident in the skills of staff. They also felt staff ensured people received care and support that was effective. A relative said, "My relative has so much support to enable him to live a more full and enriched life within the care environment". Another relative of someone who had been at the service for a shorter period of time said, "Staff are on the whole trained well as they and my relative get to know each other. Staff have done their best to identify all of his needs and update the GP and hospital. I am also always kept informed [and involved] with the current situation."

Each person who moved to the home had their needs assessed before they moved in. Care plans were put in place to make sure staff had the information they required to deliver care to meet people's needs. Staff attended any specific and complex procedures training before a person with special requirements was admitted. The care plans were constantly reviewed and refined to ensure people's needs were being correctly identified. We found a close link to staff training, people's current care needs and in how the service worked closely with the person, a range of health and social care professionals and family. Evidence based practice was utilised at every opportunity and reflected on in the MDT meeting to see how this was or not meeting people's needs and if other approaches would work better. Rehabilitation of the person was seen as needing to involve the person, their family and other key people in their life. The service had identified the need to work with close relatives and friends to identify and address their reaction to the changes in their loved ones. Staff then supported the emotional journey of all while also supporting the person in their physical one. A GP told us, "[Waters Park] has a multidisciplinary team that work together to provide good, appropriate care to all their patients".

One person said, "I am happy with the way I'm being looked after; more than I expected" and another, "I came here in wheelchair, now I can mobilise".

People's health needs were met as part of the closely linked MDT and by community based health services. Staff had worked hard since our last inspection to reach out to other professionals and make Waters Park a key resource for people who had an injury or condition that affected the functioning of the brain. Part of their skill was identifying in people, who could not communicate, individual reactions to pain and illness; and then working together to identify when a person had additional health needs before this was too advanced. A relative told us, "I feel his health needs are met to a high standard, never seems to have a problem getting to see his GP and staff respond very quickly to our concerns regarding his health".

People's needs in respect of food and hydration were met in a personalised manner. This was met with a determination on behalf of staff to ensure people at risk of malnutrition, or who had changes in eating due to their injury, had this need met in a creative manner. Food was prepared to be available for a time span rather than at specific meal times. People could eat when they wanted in line with their choice and mood. For example, one person would eat 'on the go' and food was prepared for them to do this and so maintain a healthy weight. A relative of another person told us, "He often refuses to eat and has lost weight. Special efforts are being made by reducing his portion size and producing food often. Also, they are giving me a meal at the same time to persuade him to eat."

People had drinks provided as and when they wanted them. Staff were observed to be constantly offering drinks and snacks to those who could have them. People who required their food and drinks provided in a specific way had this completed in line with their care plan. Another relative said, "The food and drink are monitored very well, my relative would suffer malnutrition if he had to fend for himself". There was evidence of regular input from dieticians, nutritionists and swallowing assessments and action plans from Speech and Language Therapists.

Some people required feeding via the stomach (PEG fed) and this was given as required along with any supplements and medicines. This was completed discreetly as part of the person's normal routine while they were in the lounge area.

People said of the food, "Food, beautiful innit" and, "Lovely food, I eat in [my] room".

We rechecked whether the service was working within the principles of the Mental Capacity Act (2005) (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

We found the service ensured the five principles of the MCA were practiced with each person. For example, this meant they assumed everyone had the ability to consent (Principle one) and given the right support could make their own decisions (Principle two). Any limitations a person's ability to consent was kept under constant review. Staff ensured people's right to make unwise decisions (Principle three) and where they were making decisions on behalf of people, this was made in their best interests (Principle four).

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are

called the Deprivation of Liberty Safeguards (DoLS). DoLS were applied for as required to keep people safe. In any event, staff ensured they worked using the principle of least restrictive practice (Principle five) and kept the needs for a DoLS under review. People with a DoLS were supported to access the community in a way that advanced their being part of the community but in a safe way with clear risk assessments in place.

We observed staff supporting people with their consent. People told us they had the choice of how to spend their day. Comments we received included, "It is my decision to eat in my room"; "I choose [my] own clothes"; "I am going out tomorrow; I go out once a week" and, "I go out on my own to the park".

People had the required equipment to meet their rehabilitation and longer term needs. Some people had their own self-contained accommodation that was specially designed to enable them to complete tasks such as cooking, washing their own clothes and live independently with support on hand. People's rooms were personalised to their wishes should they require it. The wider building décor needed attention to enable it to reflect current guidance in respect of working with people with a level of confusion such as living with dementia. This would also include the dining room, lounge and the use of appropriate signage. We discussed this with the registered manager and MDT who started to look at ideas of how this could be improved.

Good

Is the service caring?

Our findings

The service continued to be caring.

People continued to be cared for by staff who were caring, compassionate and respectful. Staff were passionate about people and wanted each and every one of them to achieve their best in life following their brain injury. Staff spoke to us about seeing the ability as opposed to the disability in people. All interactions we observed from all grades of staff were respectful.

People were observed to be comfortable in the company of staff and family members told us they were happy with how staff cared for their loved ones.

People told us, "I am happy"; "Fantastic, staff [are] like family"; "People here are brilliant" and, "I am still happy living here".

A family member told us, "Staff understand his unusual sense of humour. We always feel very welcome and the staff are always pleased to see us; it is good to see the banter between them and my relative. They treat everyone with respect".

Another relative said, "The atmosphere is always warm and comfortable. Staff always seem kind and compassionate. They are courteous, understanding and always knock before entering rooms. They pacify my relative when he becomes agitated."

We saw notes and cards from families complimenting and thanking staff for their care. Staff interacting with people, displayed good knowledge of people's personal likes, dislikes, interests, past lives and family situations. There was an ethos of assisting people to achieve their optimum but also respecting when people wanted their own space. We noticed that even when asked to go away by someone, if they seemed distressed, staff would observe from a distance.

People were encouraged to have maximum control of their care and to make decisions about their day. There was evidence in people's records that staff had obtained a comprehensive record of individual views and decisions. When appropriate families and friends were also involved. The MDT also took into account individuals' views. Where that was not possible other means of communication were tried and interpreters were used for people who English was not their first language. For example, one person had an interpreter visit twice a week to check they were alright and there were no issues staff had not understood. People also had external advocates specially trained to use their chosen communication method to ensure staff and management were up to date on their needs. A GP said, "They use all available methods to allow clients to communicate to the best of their ability".

Staff acted as key workers for individual people. Practically they made sure they had their desired toiletries available but they also spent time with people so they knew their needs better. A staff member said, "I like to get to know people well so when they have no verbal communication I can make them as comfortable as

possible."

People were encouraged to be as physically and psychologically independent as they could be. People were encouraged to regain their confidence in their own skills in looking after themselves where this was possible. Staff approached people in a holistic manner and continued to work with people to obtain the goals that were important to them. Staff understood that people could become frustrated during this process and may present behaviour that would challenge other services. At Waters Park House it was seen as another opportunity to learn about people. One person did comment to us, "The staff are lovely, in spite of the horrible things I said to them".

Family members told us that they were always welcomed and refreshments were provided as needed. One told us, "We are always welcomed and we can come and go with ease".

Good

Is the service responsive?

Our findings

At our last inspection in February 2017 we rated this key question as Requires improvement. This was because people's care records did not always reflect the person's current care status. There was no system as to when the written care plan was updated and no audit.

We found on this inspection that the concerns had been addressed. We have now rated this question as Good.

Following the last inspection, people's records of their care needs had been reviewed and rewritten. People's care records now demonstrated their current care status and care plans were audited to check this was maintained.

People told us, "I am happy with the way I'm being looked after, more than I expected" and, "They are doing a good job caring for me". Where people had struggled in other care services, "Really happy, best care I've ever had" and another, "I have done better here".

Each person had a care plan which set out their needs and how their needs would be met. Each person's care plan was unique to them and highlighted their needs and how staff were to support them. People's care plans were honed to their needs as staff got to know them. People were supported to identify goals for their time at Waters Park with management plans in place to give steps on how to achieve these. Translators, advocates and assisted technology were used to achieve this with or on behalf of people. Family and people special to those living at the service were actively encouraged to take part in the rehabilitation programme. This meant family and friends attend physiotherapy sessions so they could understand how to support their loved ones physical development. Staff told us, "Our work is also with the families; they have also been impacted by what has happened to their relative. We speak to [one family member] often and listen to them. Relatives know they can come and get us at any time". Another staff member said, "We have to help both to adapt to the change in their life circumstances".

A family member said, "They have always involved me in his care" and another, "We have had a great deal of input into my relative's welfare and social needs package".

A staff member said, "The centrality of the person is key with joined up working; that is internally and with GPs and outside clinical staff".

People were viewed as a whole with holistic approaches put in place. This meant the MDT made up of psychology, physiotherapy, occupational therapy, speech and language, nursing, catering and rehabilitation assistants each had their place and communicated well together to meet people's needs. We found staff were extremely passionate about people and what could be achieved for them and with them. This included staff working closely together as a team and with external agencies to receive the maximum positive outcome for people. We also found that when 'the plan' was not going right for people, the MDT questioned each other in an open way to challenge themselves to what they could be missing. New plans were then put

into action and continuously reviewed. A GP told us, "Staff provide a personalised and responsive care package".

A family member told us, "He was in two care homes before coming here, this one has helped him most" and another, "I'm very happy with the care he's getting". A third family member said, "My relative has complex needs which are being met and he has specific care personalised for him".

Waters Park used a tool called TOMs (Therapy Outcome Measures) which is based on the World Health Organisations International Classification of Functioning, Disability and Health. It assesses five therapy goals and reviews people's progress over time. One person, who had recently been accommodated at Waters Park and was now home had been assessed using the TOMs and over their time they more than doubled their outcome measures. This person had very complex physical and psychological needs and had not been able to have their needs met in other care services. Following a detailed initial assessment by the MDT, the person moved to Waters Park for rehabilitation. A detailed care plan was created that addressed their complex needs with the person's full involvement in setting their goals. Each member of the MDT concentrated on their area of work but sometimes worked together as well. External professionals were also closely involved. The care plan and goals were reviewed at regular intervals. The person was also linked to community groups and took up meaningful activities; this was backed up by careful risk assessing and working with the person to identify people of risk. Staff work on their physical needs, social needs, anxieties and self-confidence. The person practiced a faith that was very important to them and staff ensured this was not neglected.

Practical help was also sought to support the person in moving on from Waters Park. They went home medically well and mobile. A professional wrote to the service at the time stating they were contacting staff due to, "The excellent support you had given [the person]" and, "the encouragement and work you had done to improve [their] mobility, strength and well-being". The person has remained at home supported by family who received telephone support for some weeks after they left to ensure their ongoing rehabilitation in the community.

People had hospital passports in place which detailed their care plan in a quick access format. This meant people's needs could be met on visits or admission to hospital. Strategies were included to maximise how best to communicate with the person.

People had busy days at Waters Park with some coming and going to take part in groups in the community or go shopping or visiting family and friends. Some structured activities took place but the concentration of a lot of people living there was short, so activities were often spontaneous. Waters Park have their own transport and this was used often during the inspection. People had their faith needs met by visiting faith leaders as needed and they could access faith services in their community.

People were encouraged, along with their family, to think about their end of life and how they would want this to be met when the time comes. As a GP told us, "They don't have many end of life patients but are fully capable of meeting the needs of end of life patients". Staff told us they had recently thought more about how to meet people's end of life needs having had one person they had known for a long time die last year. They described how difficult this had been and felt more preparation would be helpful. This led to the nurse manager completing the Six Steps training with a local hospice. Other staff are undertaking and planned to take the same training.

A complaints policy was available. People were supported to complain and raise concerns as needed. Assisted technology, advocates and interpreters were utilised to support this process as needed. Staff told

us they were aware of how people communicated and any change in their presentation would be looked at to check if something was wrong. Family members told us they had not needed to raise a formal complaint. One family member said, "We feel happy to raise any minor, informal concerns directly with the care manager or their team". Another relative said, "You just have to ask and they deal with it."

Good

Is the service well-led?

Our findings

At our last inspection in February 2017 we rated this key question as Requires improvement. This was due to the service not telling us of key events as they are required to, the provider was not ensuring there were clear systems in place to measure the quality of the service and, people told us there was no way to formally feedback about the quality of the service.

We found these concerns had been addressed on this inspection. We have now rated this question as Good.

A registered manager was in place to manage and oversee the running of 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 registered manager was also the provider. They were supported in their role by a care manager, a nurse manager and a multi-disciplinary team (MDT). The MDT was made up of qualified nurses, occupational therapists, a physiotherapist, a psychologist, a speech and language therapist and rehabilitation assistants.

The management team had an excellent knowledge of the people who lived at the service and the staff who supported them. They spent time in all areas of the service which enabled them to constantly monitor standards. People were very relaxed and comfortable with them and described the management team as approachable. Family and staff all commented they felt the registered manager, care manager and nurse manager were all open to new ideas and took any option to learn and develop. Staff also felt they could also approach other colleagues in the MDT for support and guidance as relevant.

People told us, "The management is good" and another, "The team is good". A relative told us they felt the management was approachable and, "They are always around". Another relative said, "We feel the service delivered is of a high quality". All stated they felt they could make suggestions about the service which were then listened to.

A staff member said, "The team is now a really good team that works in unison with each other."

Following the last inspection a number of audits had been put in place to monitor parts of the service. Action was always then taken on any concerns. This meant care plans, medicines, infection control, falls and accidents and the environment were reviewed often to check the safe running of the service. People, family, staff and visitors had been asked to give their written response to feedback on the service. This was via a questionnaire. Staff meetings were also held to enable staff to share their ideas. The provider and MDT used the feedback, complaints and incidents to continually improve the service. They also responded well to the last inspection, using it as a means to improve the service for everyone. All staff expressed this would continue in the future.

One member of staff said, "Since the last inspection we have tightened our procedures; sharing information

better in internal communications. The MDT has brought in clearer recording. There is now a better flow of information among the whole staff team".

The registered manager and care manager ensured they notified the Care Quality Commission (CQC) of any significant events which occurred in line with legal obligations. Relevant agencies were informed of incidents and significant events as they occurred. This demonstrated openness and transparency and they sought additional support if needed to help reduce the likelihood of recurrence. The registered manager also promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

We found staff were clear about their roles and responsibilities and could work both independently and collaboratively. Work was continually underway to ensure good communication internally and with external health and social care professionals. Staff were passionate about seeking opportunities to continually improve the service for people living there. For example, communication was currently underway with a local university to explore the use of virtual technology and its ability to improve depression as a consequence of having a condition affecting the brain. A GP said, "They work very well with the surgery and communication is regular and appropriate" adding, "They seem to work well as a team providing good patient care".

The provider had a clear vision for the service which was to maintain a caring environment where people received good quality, personalised care. This was achieved through the MDT and by on-going monitoring and liaising with other professionals to ensure people had access to all available resources and advice to meet their needs. The vision and values were communicated to staff through meetings and training. Comments from people, relatives and visitors showed the vision for the home was put into practice.

The care manager, who had just completed their level 5 Diploma in care, told us, "We can still learn, change and find a new sense of direction. New Ideas, new team ways of working and reflection are all important. Since the last inspection the team has worked hard aim to continue to reflect."