The Disabilities Trust

The Maples

Inspection report

Tokers Green
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22 November 2016

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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

We inspected this service on 21 and 22 November 2016. This was an unannounced inspection.

The Maples is a residential care home registered to provide accommodation for persons who require nursing (without) or personal care. They support up to 15 people who have autism and accompanying learning disabilities. The service was supporting 14 people at the time of inspection.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being managed by a manager who had applied for registration with the Care Quality Commission.

At an inspection in September 2015 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider sent us details of how they would meet their legal requirements relating to the three breaches.

At this inspection we found improvements had been made. People felt safe and were supported by staff that had the skills and knowledge to meet their needs. The service was continuing to work on recruiting to vacant posts and in the meantime took measures to ensure temporary staff were of a good standard. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

Relatives felt people were safe. Staff had a clear understanding on how to safeguard people and protect their health and well-being. People received their medicines as prescribed. There were systems in place to manage safe administration and storage of medicines.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. These were regularly reviewed and updated when needed. Staff were aware of people's needs and followed guidance to keep them safe.

People were supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager). Staff received adequate training and support to carry out their roles effectively.

The manager and staff had a good understanding of the Mental Capacity Act (MCA) 2005 and applied its principles in their work. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA.

People were supported to maintain their health and were referred for specialist advice as required.

People and relatives were involved in decisions about people's support needs. People had care plans which detailed the support they required and how the support would be provided. Care plans were regularly reviewed and updated. Staff knew the people they cared for and what was important to them. Staff supported and encouraged people to engage with a variety of social activities of their choice in the community.

The service looked for ways to continually improve the quality of the service. Feedback was sought from people and their relatives and used to improve the care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

The manager informed us of all notifiable incidents. The manager had applied to become a registered manager and had a clear plan to develop and further improve the service. Staff spoke positively about the support and leadership they received from the management team.

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.

People's safety was managed by any concerns being appropriately reported and investigated. Staff had safeguarding training and understood what abuse was.

Risks to people were managed and assessments were in place to manage these and keep people safe.

Medicines were managed safely and staff's competency was checked regularly.

There were suitably qualified staff to meet people's needs. Where temporary staff were used the provider ensured these were regular and appropriately trained staff.

Is the service effective?

Good

The service was effective.

Staff were carefully selected to ensure they had the required skills and experience to meet people's needs.

Staff received relevant training and this was kept updated.

Staff felt supported and had regular meetings with management to discuss their roles and responsibilities.

Staff had good knowledge of the Mental Capacity Act and applied its principles in their day to day work.

People had access to, and were supported to attend medical support when needed.

The service had plans to improve the décor and furnishings of the premises.

Is the service caring?

Good

The service was caring.

People were supported by staff that knew the importance of treating them with dignity and respect.

Staff were mindful of the ways people wanted to be communicated with.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were current and reflected individual support needs. People's care was reviewed and changes made where needed.

People were encouraged to take part in activities they enjoyed.

Complaints were responded to in line with the provider's policy.

Is the service well-led?

Good

The service was well-led.

The leadership created a culture of openness that made staff and people feel included and well supported.

Staff said the management team was a positive improvement to the service they valued being listened to and action taken.

There were systems in place to monitor the quality and safety of the service and drive improvement.

The service worked well with other professionals to ensure people had good outcomes.

The Maples

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 inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 21 November 2016 and was unannounced. We also visited on 22 November 2016 to complete the inspection.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We obtained feedback from commissioners of the service.

We spoke with one person and two relatives. We looked at four people's care records including medicine administration records (MAR). We spoke with the manager, operations manager, and seven care staff. We reviewed a range of records relating to the management of the home. These included four staff files, quality assurance audits, people's surveys, minutes of meetings with staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

At an inspection on 5 October 2015 we found medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 and 22 November 2016 we found improvements had been made. People received their medicines as prescribed. The provider had a medicines policy and procedures in place and there were systems in place to manage medicines safely. Staff had completed medicines training and their competency in administering medication was checked regularly. Where staff were required to have training specific to a person's prescribed medicine, this was completed by an approved health professional before staff supported the person. For example, all staff who supported people with epilepsy had received training to administer emergency medication.

Records relating to the administration of medicine were accurately completed. Medicine administration records (MAR) detailed medicines administered from a monitored dosage system. Some people had been prescribed medicines to be administered on an 'as required' or occasional basis (PRN). We saw that guidance was provided within Medicines Administration Records (MAR) on how PRN medicines should be administered, should they require it. The provider maintained records of when these medicines were administered and the reasons for their administration, for example, signs that a person may present with that may need the use of laxative medication.

People's care plans included risk assessments and where risks were identified there were management plans in place to manage the risks. Risk assessments included risks associated with people's medicines, behaviours and the environment. For example, we saw a person had a risk assessment for when they were in a vehicle so staff would know the best place for the person to sit to minimise any incidents. There were also risk assessments in place for bathing, fire evacuation and activities. We also saw that some people had guidance around reducing behaviours when they were agitated and any interventions that may be needed, with physical restraint as a last resort to protect the person or other individuals.

People who had epilepsy had risk assessments in place. These included what action to take if a seizure occurred and when to call the emergency services. There was information on observing people frequently. We saw on one person's records that some monitoring equipment should be investigated to see if this would reduce the risks further. We did not see this had been followed up. We spoke with the manager about this who agreed this should be actioned immediately and we saw an email send to the learning disability nurse during the inspection for guidance and assessment. After the inspection, we were told that the nurse had arranged to visit the service to discuss further. The manager had also raised the matter at the managers meeting and with the local and divisional governance team to ensure good practice was shared and ensure action on recommendations made.

People were supported by staff that had the appropriate skills to keep them safe. This was because staff had undergone training in areas such as safeguarding, first aid, health and safety, medication, infection control and training about epilepsy and emergency medication to manage seizures. Mobile phones were provided

for staff to use when people were supported away from the service. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. All staff understood their responsibilities to identify and report any concerns relating to abuse of vulnerable adults. Staff knew where to report to outside agencies and named the Care Quality Commission (CQC) and the local authority safeguarding team. One member of staff told us, "Vulnerable people need to be protected from abuse and harm".

People benefited from staff that understood and were confident about using the whistleblowing procedure. There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy.

Where needed, people had behaviour support plans in place to enable staff to interact in a positive way to help understand and manage any behaviours that may challenge. Details included when behaviours may occur, for example, a need not met which may trigger a behaviour. What the behaviour means – for example, no longer wanting to participate in activity and what strategies to try to manage the situation. For example, during the inspection a person was very upset due to an incident earlier in the day. We saw the behaviour escalating during the day and saw staff were supporting the person to try to reduce escalation of the situation. This had been recorded on the observation form as these were then analysed by psychology to see if any other strategies were needed to be put in place.

The provider recorded and reported accidents and incidents appropriately. Records clearly documented when incidents and accidents had occurred and what action was taken following the event. For example, we saw an incident reported after a person hurt their foot on a holiday and was taken to hospital to have it checked out. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. One member of staff said, "We report any accidents or incidents to the office and complete accident forms".

Staffing levels were maintained at a safe level with use of agency staff but the manager was continuing to recruit staff to permanent contracts. In the interim, measures were in place to ensure agency staff were suitable by using an on-line system where the manager could look at staff profiles, and their training and either accept or reject them. Where possible, the same staff were supplied to ensure continuity and knowledge of people supported in the service. We saw safe staffing levels had been maintained.

The service operated an on-call system to ensure that staff had advice when needed. The assistant managers worked shifts to ensure adequate management support was provided mornings, evenings and weekends. We asked staff whether they felt there were enough staff said and comments included, "With the new management, yes" and "It's okay, has improved a lot".

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable people.

Environmental risk assessments were also in place to ensure all equipment was safe and used correctly. Contracts were in place for the servicing of all equipment on site. Fridge and water temperatures were

checked to ensure they were within range. A maintenance person was employed full time to ensure that repairs were undertaken in a timely manner.

Good

Is the service effective?

Our findings

At our inspection on 5 October 2015 we found staff had not received the support they needed to undertake the roles and responsibilities. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 and 22 November 2016 we found improvements had been made. Staff were supported to improve the quality of care they delivered to people through training and supervision processes. All staff had received regular one to one supervision meetings with their line managers. This gave staff the opportunity to discuss their performance, raise concerns and identify any development needs they might have. Regular observations were also carried out on all staff to monitor the quality of care. These identified any areas where the quality of care people received could be improved. Staff spoke positively about their experience of supervision and welcomed any feedback to improve their practice where they could. One member of staff told us, "Yes, I have supervision regularly. This is much improved".

Annual reviews of staff performance were still to take place. This was because the management team were fairly new in post and they wanted to get to know the staff better through the one to one meetings before undertaking a review of their performance. The annual reviews had been scheduled for all staff.

New staff completed a comprehensive induction programme before working on their own. Staff were beginning to undertake the care certificate training to enable them to be more effective in their approach and have more confidence. The Care Certificate is a set of standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The induction programme included training for their role and shadowing an experienced member of staff. The induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. One member of staff told us, "I read the policies and did shadowing and e-learning, I also completed training such as safeguarding. This helped me know what measures to take such as reporting and recording on body maps if needed".

Staff records showed they had received the provider's mandatory training on a range of subjects including person centred lifestyles, nutrition and wellbeing. Staff told us they had the training to meet people's needs. One member of staff said, "I've had lots of training such as medication, first aid, epilepsy, moving and handling. We have some training soon on Makaton". Another said, "I've received e-training for medication in the last few weeks because my current certificate expires next month. Medication checks ensure that people have understood their training".

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The manager was knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected. For

example, we saw that a person had been assessed as not having capacity about moving to The Maples or managing their medication. However, they did have capacity around some aspects of managing their finances. Capacity assessments were reviewed to ensure they were still relevant. We also saw that people's capacity was assessed in line with the principles of the MCA, for example, providing all opportunities to assess capacity. For example, we saw someone had a capacity assessment around keeping cleaning products in their flat. This had been done by providing pictures and getting feedback from the person to identify their use and distinguish them from other products such as toiletries or food products. The outcome of this assessment was that the person had capacity to safely have these products in their accommodation. Staff understood their responsibilities in relation to MCA. One member of staff said, "I never assume the person won't be able to give consent or have a choice. I check every time".

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). At the time of our inspection, all people in the service had DoLS. Staff members described why and how people could be deprived of their liberty and what could be considered as a lawful and unlawful restraint. For example, we saw people's records detailed when physical restraint may be needed and as a last resort after other strategies had failed. All staff had received training on the safe use of restraint.

Staff were aware of people's dietary needs and preferences and these were also clearly recorded in their care plans. Staff told us they were aware of the importance of encouraging people to eat healthily. Care plans gave details such as 'Support to eat healthily'. We saw a person was being encouraged not to have as many fizzy drinks due to concerns about their weight. We saw a person had notes about ensuring their food respected their religious beliefs. Where needed a screening tool was used to monitor people's weights where there were concerns. We saw details of encouraging a person to drink fluids as they could become dehydrated. People were encouraged to participate in planning meals, shopping and cooking an evening meal. We saw one person could chop and peel vegetables and bake pizzas. We also saw there was a healthy eating session that people attended.

People had Health Action Plans. These provided information on people's relevant medical details such as allergies and medical conditions such as epilepsy. It stated the importance of relatives being kept updated. The Health Action Plan also had details of health professionals involved such as GP, neurologist, psychologist, learning disability nurse, dentist, optician and chiropodist. We saw a person saw a chiropodist every six weeks as stated in their health action plan. We also saw that someone's goal had been to improve their oral hygiene. We saw on this person's records a note from the dentist saying 'Greatly improved'. Referrals had been made where needed, for example, a referral had been made to an occupational therapist in respect to seating in transport.

Good

Is the service caring?

Our findings

At our inspection on 5 October 2015 we found staff were not always treating people with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 and 22 November 2016 we found improvements had been made. Staff had received training in dignity and respect and person centred lifestyles. Further training had been planned to improve communication skills, such as Makaton (a way of communicating by using signs) training to further assist communication. However, during the inspection we did not observe a lot of interaction between people and the staff. This may have been that people did not want to, or found it difficult to interact socially with others. On discussion with staff they did seem aware of people's needs. We saw a staff member ask a colleague to go on a run with a person as they knew they could not keep up with the person, but wanted to ensure the person got their activity.
Staff were respectful of people's privacy and maintained their dignity. A staff member said, "[Name] sleeps with their curtains open. When I dress [name] in the morning I always ensure that I close the curtains". Throughout the day, we heard staff knock on people's bedroom doors before entering.
We spoke with a relative of a person in the service. They stated, "This is one of the best homes that [name] has lived in. [Person's] flat is like a palace to him". They went on to say that the staff who cared for their relative were ideal because they had a sense of humour and understood and distracted when needed. We spoke with another relative who was visiting and they said they were "Very happy with the care".

Support plans were written in a respectful manner and people had been involved in these and signed by people to confirm they agreed with the way their care needs would be met. People had up to date communication profiles to ensure that staff were able to communicate more effectively with them. For example, information was recorded about whether a person communicated verbally or non-verbally. It explained whether they had any reading skills and indicated how the person would say yes or no to something, either verbally or by body language. It also gave information on the best time to have the most effective communication interaction such as 'When I'm in a good mood'. There was a description of how people may express their moods such as when happy or scared. For example, if scared they would ask lots of questions and seek reassurance. The management team were providing mentoring for staff around interpretation of body language and attitudes and values. We saw a person gave a sign for a drink. The staff member responded immediately to their request. We later found out that failing to recognise the signing could have resulted in behaviours escalating. Further training for staff around positive interactions with service users was also planned to give staff further understanding of positive communication.

We also saw records on staff supervision notes about the need to encourage people's participation in activities. Observations were also done on staff by the management team and any interactions that were not deemed to be appropriate were challenged constructively and discretely to improve staff understanding.

Confidentiality was recognised important. We saw notes on people's health action plans stating the

information was 'Personal to me' and to keep information confidential. We also saw guidance about ensuring a person had private time when making phone conversations for a period of time but that after a while the person may need re-directing to another activity as boundaries were difficult for the person. A staff member said, "Many people don't talk but if someone does have a private chat you may have to tell a manager but no one else".

Independence was encouraged. For example, a care plan noted the importance of encouraging a person to identify prices, pay and collect change and receipts. We observed a person and member of staff working together to vacuum the person's room. The staff set-up the vacuum cleaner and then instructed the person how to use the vacuum cleaner.

People were supported to have contact with their families and those important to them. One person returned to the service with his parent and we saw that going home on visits was a regular occurrence for the person. The importance of developing and maintaining family relationships was also recognised by the management team as important to create effective communication with families.

Good

Is the service responsive?

Our findings

People were assessed before moving to The Maples to ensure the service could effectively respond to their needs. These assessments were used to complete person centred support plans and people were involved in the planning as much as possible. For example, we saw recording on the plan stating, '[Name] likes to be highly involved in the planning of their support, generally responding well to a collaborative approach. [Name] particularly enjoys describing their interests and finding new activities to undertake. Additional information has been gathered from [name's] relatives (who are closely involved in his care) and from members of staff who know [name] well.

Support plans were person centred, up to date and detailed with outcomes and actions stated to ensure people were supported to achieve as much as they could. Personal details were recorded which included preferences, religion, preferred names and hobbies. People's daily routines were detailed in their support plans. For example, getting up early to wait for morning staff and going to the office for a chat. This meant that staff understood the importance of keeping to this routine.

Support plans also included communication and autism profiles, behaviour support plans and risk assessments, including the use of any potential physical intervention risk assessments. These enabled staff to respond in a positive, tailored way, to meet the needs of individuals. For example, the autism profile had information about how a person preferred to engage such as 'Has good eye contact and engages in conversation' and 'Can become preoccupied with staff'. Guidance was incorporated such as how to help the person manage social boundaries.

A colour coded system was used to highlight important information. For example, 'Things you must know' gave details of medicines, allergies and epilepsy. 'Things that are important' gave details around communication, eating/drinking, risk awareness and 'Likes and dislikes' provided information on being included in discussions, activities enjoyed such as photography and train/bus journeys. It also gave details of dislikes such as 'Changes and things being imposed on me and told what to do'. There was information on areas such as 'If I need to have treatment using a needle'. Guidance was would tolerate injections but also known to refuse. The situation was assisted by the person being in a good mood and supported by familiar people and explaining why the procedure was needed. This meant people were supported by having detailed care plans which were individualised to their needs.

Action plans were used to assist staff in working effectively with the person to develop their potential. We saw details of a meeting between a key worker and a person who had requested changes on their activity planner. It was decided the person wanted to use public transport more. We saw records that this had been achieved in the person's daily records which had details of trips on the bus to town.
People's support plans were reviewed regularly. The service had developed a schedule indicating when the next planned reviews for support plans and health actions were due. This meant that people's care needs would be kept updated and consultation was made with the appropriate professionals to review people's care.

People had a range of activities either planned or on offer. For example, people had recently taken part in a bonfire night party. We saw this had aimed at providing an age appropriate activity. We saw photographs and a 'Guy' had been made, fuel from the local wood collected and firework cakes and biscuits baked. The speech and language therapist had provided Makaton signs for bonfire night to assist communication for some people. There was also discussion about the tradition of bonfire night and Guy Fawkes.

Where people had set goals such as attending college records confirmed these goals had been reached. Other activities on offer included, shopping, canoeing, walks, picnics, cycling, cinema trips, theatre trips, arts and crafts, line dancing, drumming, cookery and social evenings, etc. We also saw a trip to London had taken place with compliments received from the person's parent.

People attended meetings to gain their views and respond to their needs and wishes. We saw records of a meeting discussing the upcoming Christmas pantomime. People chose which pantomime they wanted to do and chose Snow White and the Seven Dwarves. Auditions had been held and it was reported that there was a lot of enthusiasm. We spoke with one person who told us about their role and told us their lines they were learning. One person was doing the photography for the pantomime as this was a particular interest of theirs. We heard the manager was being lined up for a custard pie in her face! Other meetings had discussed healthy eating and shopping. A 'talk cube' was passed around to ensure everyone got a chance to have their say.

We heard a person had attended a pop concert and sat in the front row to see one of their favourite bands. It was reported the person could not wait to go to another concert in the future. Three people had recently enjoyed meals out at local eateries. Due to issues with crowded places and noise levels this had not been possible before. This activity was now forming part of their planned activities to develop skills and improve community interactions.
A newsletter was sent out and these mentioned birthdays celebrated. For example it mentioned that a person had a birthday cake made for them by another person in the service. Two other people had baked cakes and biscuits.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People were provided with information of how to make a complaint or compliments as well as contact information for the local authority and CQC. We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to. For example, complaints had been made about how people's clothes were looked after. The service changed the laundry procedure and people had their own baskets in the laundry to avoid clothing getting mixed up. At the last inspection there had been complaints about contacting the service. We found this had been improved by replacing the telephone system.

Good

Is the service well-led?

Our findings

The service was managed by a service manager who had applied to become the registered manager. The manager had many years of experience in the social care sector and held management qualifications. They had been at The Maples for 10 months and demonstrated strong leadership skills and a clear vision to develop and improve the quality of the service. The manager had been offered a permanent post at The Maples and was in the process of applied to the CQC to become the registered manager. There were also two assistant managers. Both assistant managers had management experience and qualifications. One assistant manager was currently undertaking a national qualification to support their role and both assistant managers were scheduled to begin the company's management development programme in January 2017. This was with the aim of developing the staff team further using a range of methods, to include mentoring and in-house training. There was one team leader in post and two vacancies. The management had interviewed several people but knew the importance of recruiting the right person for these posts to continue the improvements already made in the service.

There had been many improvements since the last inspection. The manager had introduced new changes that aimed to improve the way the service was run and the care people received. The manager told us their biggest challenge had been managing the service alongside making necessary changes to improve care plans, risk assessments, and improving the culture of the service. The management team had regular meetings. For example, we saw they had discussed PRN protocols and carrying out competency assessments. We also saw ongoing discussion about continuing to improve the interaction between people in the service and staff.

The manager knew the importance of making any changes in consultation with staff. Staff meetings were arranged on a regular basis. Management arranged three opportunities a month offering meetings in the mornings, afternoons or evenings. This helped to ensure all staff could attend at least one meeting a month. Management had introduced a 'You said, we did' commitment so staff could see action form these meetings. For example, new files had been developed which only contained paperwork that needed completing daily to ensure essential information was captured. The service has also purchased six mobile phones to be used by staff when out with people. This meant the staff were assured their views were taken on board. Staff felt listened to. One member of staff told us, "The provider listens to staff and acts on staff opinions".

Staff told us they felt supported by the management team. Staff comments included, "[Management] are open, listen and are excellent", and "Changes are made where needed. They do things if they are needed. I needed assistance today and the extra support was arranged. They are excellent" and "Management are approachable, co-operative and co-ordinated. After team meetings they act on what is asked about".

The manager had created an open and honest culture and staff spoke with respect about the improvements made. During our visit, management and staff gave us unlimited access to records and documents. They were keen to demonstrate their caring practices and relationships with people. Staff told us they felt the service was transparent and honest. One member of staff said, "[Manager] has open and clear expectations

and a realistic vision of where the service needs to improve".

Incident and accident logs were sent monthly to the service's organisation quality assurance department. They reviewed and analysed an action required and a graph was produced which picked up on any trends of incidents so these could be acted upon. The results of these were then reported to senior management to discuss and action or ensure any 'lessons learnt' took place.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. Internal audits had taken place on people's support plans, lifestyles, participation, recruitment, medication and nutrition to ensure that the service was monitoring and improving where identified. For example we saw an audit had been done on medicines and action needed on improving PRN protocols. There was also advice about improving the checks on medicines balances. Audits had also taken place in areas such as infection control, hand hygiene and the environment.

Staff files were audited four times a year. A schedule had been developed indicating when each staff member's supervision was next due. This meant that management ensured all staff were regularly supported to discuss their roles and receive feedback.

The service also had regular external quality assurance audits on health and safety, finances and medicines. For example, medicines had been audited by an external organisation. This has found that a person had not used a PRN medication for a long time so it was suggested this was removed after consultation with the GP.

Policies and procedures were in place to provide a robust framework for people to work within.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

The service worked in consultation with stakeholders such as the local authority and health professionals. Opinions had been sought regarding the service. Stakeholder questionnaires had been sent out but had not been returned at the time of the inspection.