Bridgewood Trust Limited

The Gables

Inspection report

Appartments 1-9
Elmwood Avenue, Highfields
Huddersfield
West Yorkshire
HD1 5DA

Tel: 01484429172

Date of inspection visit:
06 October 2016

Date of publication:
11 November 2016

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

This inspection took place on 6 October 2016 and was unannounced.

The Gables is registered to provide accommodation and personal care for up to 13 people with a learning disability or autistic spectrum disorder. People living at The Gables have their own flat which consists of a living room, kitchen, bedroom and bathroom. There are nine flats, some single, some double. There is a small communal kitchen/dining area and living room. At the time of our inspection 10 people were using the service.

The service is required to have a registered manager, and at the time of our inspection there was no registered manager in post. There was a manager and they had submitted their application to become the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had policies and procedures in place to guide staff in safeguarding adults, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm.

Medication was appropriately stored, administered and recorded on medication administration records. An issue on one medication record was addressed on the day of our inspection. Staff responsible for administration of medication had received training and the registered provider completed staff competency assessments. This showed that there were systems in place to ensure people received their medication safely.

The registered provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. The registered provider had systems in place to ensure there were sufficient staff available to keep people safe and meet their needs. Staff completed a range of training and received supervision and appraisal to help them carry out their roles effectively.

The registered provider sought consent to provide care in line with legislation and guidance. Staff had completed Mental Capacity Act 2005 (MCA) training and were able to demonstrate an understanding of the principles of the MCA. The registered provider ensured that any conditions on people's Deprivation of Liberty Safeguards (DoLS) authorisations were adhered to.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had accessed a range of healthcare services where required, such as GPs, occupational therapists, epilepsy nurses, cardiologists, dentists and the community mental health team. People received

appropriate support with their nutrition and hydration and we received positive feedback about the quality and variety of food available. Staff supported people to prepare their own meals where they were able to.

People told us that the staff who supported them were caring. People also reported that they felt their privacy and dignity were respected. We saw positive and friendly interactions between staff and people who used the service. Staff promoted people's independence wherever possible, and progress towards people's goals in relation to the development of independent living skills, was monitored. Support was provided to enable people to maintain regular contact with family and friends and visitors were welcome at any time.

Care plans were reviewed regularly and contained information about people's needs and preferences. Staff were also able to demonstrate a good understanding of people's needs, in order to provide a personalised service.

There was a complaints procedure in place and people who used the service told us they knew how to raise a complaint if they needed to. People also had opportunity to raise concerns or give their views in residents meetings and through individual review meetings.

There was a quality assurance system in place, which included satisfaction surveys, monthly service audits and quarterly health and safety audits. There was evidence that systems in place had resulted in actions being identified and addressed where required.

Feedback about the management of the service was positive and comments from staff indicated there was a person-centred culture at the home. People who used the service told us they were happy living at The Gables and relatives also expressed a high level of satisfaction with the care provided.

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.

The registered provider used a robust recruitment process and appropriate checks were completed before staff started work. This ensured that people were supported by staff who were considered suitable to work with vulnerable people.

There were systems in place to protect people from avoidable harm. Risks to people were appropriately assessed and managed. Staff had been trained in safeguarding vulnerable adults and knew how to respond to any concerns.

There were systems in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received an induction, regular refresher training, supervision and appraisal.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People had access to healthcare services, where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and that they had positive relationships with the staff that supported them.

People we spoke with felt that staff respected their privacy and dignity, listened to their views and promoted their independence.

Support was provided in relation to people's communication

needs.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and detailed care plans were in place to enable staff to provide personalised care. Staff demonstrated a good understanding of people's individual needs and preferences.

People were supported to access a range of social and leisure activities.

There were systems in place to manage and respond to complaints and concerns, and to listen to the views of people using the service.

Is the service well-led?

Good

The service was well-led.

Feedback about the management of the service was positive and staff were provided with the support they needed to deliver the service effectively.

There was a quality assurance system in place, which enabled the registered provider to monitor the quality of the service provided.

The Gables

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 took place on 6 October 2016 and was unannounced.

The inspection team consisted of one adult social care inspector.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from Kirklees Council's contracts and monitoring team and Kirklees Council's safeguarding team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with seven people who used the service and eight relatives of people who used the service. We also spoke with three care staff, a member of domestic staff and the manager. We looked at three people's care records, six people's medication records, three staff recruitment files, staff training files and a selection of records used to monitor the quality of the service.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at The Gables, and everyone we spoke with said they did. People told us, "I feel really safe. I don't have any problems" and "I feel safe; I have my own flat." Relatives we spoke with were also unanimous in their confidence that their relatives were safe living at The Gables.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. They also had a copy of the local authority's safeguarding procedure available to staff. All staff received training in safeguarding adults and staff we spoke with demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Safeguarding records showed us that concerns raised had been reported and appropriate responsive action taken.

The registered provider had a whistleblowing policy, which enabled staff to report issues in confidence and without recrimination. Staff were aware of the policy and told us they would be comfortable using it if they had any concerns. This showed us that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

People had appropriate risk assessments in relation to their individual needs. These included assessments in relation to physical healthcare needs, personal care, mobility, security and use of transport. Risk assessments were generally reviewed every six months, or more frequently if required. We saw evidence that people had been involved in decisions about risk, such as accessing the community independently. Individual care files also contained behaviour management plans where required, to guide staff how to respond to incidents of verbal or physical aggression, and staff were trained and knowledgeable about how to respond in these situations.

The registered provider had an up to date fire risk assessment, fire evacuation procedure and evacuation guidance available for staff. Individual needs were assessed and considered. For instance, due to one person's hearing difficulties they had a vibrating pillow to alert them if the alarm was activated during the night. Staff we spoke with were aware of the evacuation procedures.

We saw that records of any accidents or incidents were completed by staff. The registered manager completed a log of all incidents, in order to ensure that appropriate action had been taken in response to any incidents. Records of accidents or incidents were also sent to the area manager, who checked the action taken.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that equipment was regularly checked and serviced at appropriate intervals. This included the electrical wiring, fire safety systems and extinguishers, emergency lighting and portable appliance tests on portable equipment. These environmental checks helped to ensure the safety of people who used the service.

We looked at the systems in place to ensure people received their medication safely. The registered provider had a medication policy. We saw that staff responsible for the administration of medication had received training in medication management and were assessed for their medication competency.

People's care files contained details of any support required with medication. We looked at a selection of medication administration records (MARs). We found these were appropriately completed, to show that people had received their medication as prescribed. There was an error on one MAR we viewed, as the record showed the incorrect frequency for administration of one medication. Whilst the person had been receiving their medication correctly, in line with the instruction of the doctor, the registered provider should have ensured the pharmacy had amended the MAR, to avoid any potential confusion for staff or risk of incorrect administration. The registered provider discussed this with the pharmacist on the day of our inspection. We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs. There were protocols in place for people who were prescribed medication for use 'as and when required'. These protocols gave clear instruction to staff when and why the person may require this medication and records were completed when people received them. Medication was appropriately and securely stored, in locked cabinets.

We observed medication being administered. On one occasion the staff member signed a MAR before administering the medication. They told us they realised they had made this mistake as soon as they had done it and would ensure they were more careful in future to only sign it once they had ensured the medication was taken. They administered all other medication correctly. When we spoke with staff about various aspects of medication management they demonstrated a good level of understanding.

This showed us that there were systems in place to ensure people received their medication safely.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for three staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We spoke with people who used the service, staff and relatives about whether there were sufficient staff to meet people's needs safely. Staff told us, "There are enough staff now that we have an additional member of staff for one-to-one support with one person who requires it. If we had any more staff I think it would be a bit overpowering for people" and "[Staffing levels] are not bad; there's no problem with this." People who used the service told us there were sufficient staff available to support them and no relatives we spoke with raised any concerns about staffing levels.

We saw from staff rotas that shifts were organised around the needs and activities of people who used the service. There were generally three care staff on shift when people were at home, on evenings and weekends. Most people attended other activities away from the home on week days, so staff were not required at these times, but on certain days of the week when some people were at home there were staff available to support them. Where required, the registered provider used bank staff to provide cover in the event of sickness or annual leave.

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers

of staff to keep people safe and meet their needs.

The registered provider had an infection prevention and control policy and cleaning schedules were in place to ensure the home was clean and hygienic. The registered provider employed a member of domestic staff to clean the communal areas of the home and care staff cleaned the individual flats, with the involvement of people where they were able to. The building was modern, clean and well maintained. We noted that the registered provider had received a score of 98% in the most recent infection prevention and control audit conducted by the local authority in August 2015.

Good

Is the service effective?

Our findings

We asked people who used the service whether they were happy with the care they received from staff and whether they thought staff had the right skills for the job. People's comments included, "They do [have the right skills]; they are very good" and "They know how to help me."

We saw records that showed us that all staff completed an induction when they started in post. There was a four week work place induction programme, which included service specific information, such as people's individual needs and risks, policies and procedures, practical information about health and safety, security, fire procedures, staff expectations and conduct. If staff did not already have a National Vocational Qualification (NVQ) at Level Two [now known as a diploma in Health and Social Care] they also completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers.

Staff completed refresher training annually for certain key topics, and other training was refreshed every three years, in line with the registered provider's training expectations. Training included safeguarding, moving and handling, health and safety, mental capacity act, inflection control, positive behaviour support, first aid, food hygiene, nutrition and diet, learning disabilities and epilepsy. The manager told us they also organised any other additional training that they identified would be useful in order to meet people's individual needs. For instance, catheter care training was booked for staff during the month of our inspection, and dementia awareness training was also planned. Staff told us, "The training is good, and I would be able to ask for extra training if I needed it" and "I've had so much training since I started."

We saw evidence of regular staff supervision and appraisal. Standard items discussed in supervision meetings included training and development, reviewing personal objectives, service user and staff issues, health and safety, infection control and policies and procedures. We saw minutes of monthly staff meetings, covering a range of appropriate topics. A communication book was also used to exchange key information between staff on a daily basis. This showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that information

was available to staff regarding DoLS authorisations that were in place and the registered provider was ensuring the conditions in these were met.

Care files contained mental capacity assessments in relation to specific decisions, such as the capacity to consent to the care plan, capacity in relation to holding a key for the front door of the building and capacity regarding the decision to use epilepsy monitoring equipment. We saw evidence in care files that people had been involved in decisions about their care. One care file we viewed also reflected the fact that the person's support needs and supervision levels varied when they were experiencing periods of ill health, and that additional support was to be withdrawn when they were well again, in order to ensure their care plan was least restrictive as it could be at all times.

Staff had completed MCA training. They were able to demonstrate an understanding of the importance of gaining consent before providing care to someone and when best interests decisions may be required. This is when health and social care professionals and other people who are involved in a person's care make a decision, on the person's behalf, because they do not have capacity to make important decisions for themselves.

This showed us that staff sought consent to provide care in line with legislation and guidance.

We looked at the support people received with their nutritional needs. Care files contained a section about eating and drinking, including food preferences. We saw one file which contained detailed information about how to respond to the person's fluctuating interest in food, due to their health needs, including how to encourage food intake when the person was declining food. People's weight was also regularly monitored. Staff we spoke with were knowledgeable about people's dietary needs and preferences.

We talked to people about the variety and quality of food available at the home. People told us the food was "Nice," "Sometimes nice, sometimes not" and "Very nice." People were involved in the preparation of their own meals, where they were able to. Relatives we spoke with were satisfied with the support provided with eating and nutrition, and the quality of meals available. One commented that their relative often choose easier options such as 'ready meals', but said this had always been their relative's preference. They told us staff encouraged healthier options, but respected their relative's choices in relation to food.

We observed a mealtime at the home and saw that people could eat in the communal room or in their own flats if they preferred. People chose to eat together and there was a relaxed atmosphere, with people chatting socially. A hot meal had been prepared but we observed that people were offered an alternative and a number of people took up this alternative option. We also looked in the food cupboards and fridges and found there was a plentiful supply of fresh food and drinks.
This showed us that people were supported with their nutritional needs.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had received support from an extensive range of healthcare professionals where required, such as GPs, occupational therapists, epilepsy nurses, chiropodists, ophthalmologists, cardiologists, dentists and the community mental health team. There were also instructions in care files where people needed specific assistance to maintain good health, such as support with epilepsy management and monitoring. Relatives told us staff were proactive in monitoring and responding to people's health needs, including people's mental health needs. People who used the service told us they knew staff would help them if they needed to see a doctor or go to an appointment, and we saw from care records that staff had regular contact with other professionals in order to support people with any healthcare needs.

Good

Is the service caring?

Our findings

We asked people who used the service if staff were caring and the feedback we received was positive. People told us, "I like all the staff," "They [staff] are all very nice people; they look after you" and "They [staff] are nice; I like them." One person said, "It's a nice home, I'm happy here. I like sitting with the staff and I keep them company." Another person indicated through non-verbal communication and nodding that they thought staff were kind.

Relatives we spoke with told us that staff, "Seem to be really nice" and "Are always very nice." Others told us, "They are very good; they treat people very well" and "They treat people as you would want to be treated yourself."

Support was delivered in a kind and caring way. Staff knew the people they were supporting well, and were able to talk with them about things they found important. We observed staff supporting one person who was becoming agitated, by distracting and reassuring them.

Staff we spoke with demonstrated a caring approach towards the people they supported. One told us, "We all have a good rapport with people here. You can tell by the way staff speak to people…The staff are all caring."

People were treated with dignity and respect. We saw that staff always knocked on the door of people's flats before entering and were respectful when addressing, or discussing people who used the service. We observed staff delivering care discreetly, such as requesting people come to a room to take their medication privately. People told us that staff maintained their privacy and dignity. One person confirmed to us, "[Staff] knock on the door." Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. The privacy, dignity and respect section of people's care plan included questions such as, 'What things make you annoyed or frustrated?' and 'What is the best way for staff to help you?' A relative told us, "They certainly treat people with respect. I've seen staff knocking on people's doors for instance, and everything that happens is age appropriate."

It was evident from people's care files that people had been involved in decisions about their care, where they were able to do so. We observed staff offering choices and responding to requests from people. Staff told us how they supported people to make choices by giving them options, such as what to eat, how they wanted to spend their days and where to go on holiday.

Staff focused on promoting people's independence. Some people only required minimal support from staff with independent living skills, such as cooking and cleaning, and some were able to access community facilities without the support of staff. This was encouraged where possible. Others required significantly more support and supervision, particularly when experiencing periods of ill health, and this support was available where needed. Care files gave instructions to staff on how to promote people's independence, and entries in people's review meetings showed where people had made progress on the development of new skills, such as learning to use the washing machine independently. We were also given examples of where

the registered provider was using explorative assistive technology solutions to promote independence, such as the use of a wristband that could alert staff to someone's whereabouts for one person who was working towards accessing the community independently.

Relatives confirmed to us that staff encouraged people's independence. One told us, "They encourage [Name] with meals for instance, but my relative doesn't always want to [prepare their own meals]. They encourage them with their self-care too. I appreciate staff are trying to get them to be more independent, but I think [Name] could do with more prompting with their personal care and clothes, but staff respect [Name's] wishes." Other relatives told us, "[My relative] can do their own room. They've always been able to do some things like this, so they encourage them to continue doing things for themselves, but help them where they need it" and "[Name] is encouraged to do things for themselves but also supported with things that they aren't able to do."

Discussion with staff indicated that there were people using the service that had particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. People's religious and cultural diversity needs were considered as part of the registered provider's initial assessment of people's needs. We also saw examples in care records where people had been supported effectively with their sexual health needs. The registered provider had an equality and diversity policy which was available to staff.

Nobody who used the service had an advocate at the time of our inspection, as people who used the service had family members who could assist them to express their views if required. Advocates help to ensure that people's views and preferences are heard. The manager told us the details of the local advocacy organisation were available at the area office if there was anyone they felt would benefit from independent advocacy. We discussed also holding this information at the service too, so that people who used the service had access to the information and the manager agreed to do this. The manager also told us that they intended to involve independent advocates when making any significant changes at the service.

Staff told us how they communicated effectively with people who used the service who did not use words to communicate, or had limited verbal communication. They told us one person had picture cards they used when required and another person responded well to staff writing things down when the person was finding it difficult to articulate their needs. Staff demonstrated an understanding of people's preferred methods of communication, including body language and facial expression. We saw clear information in one person's care file about how they communicated through an identified possession when seeing the doctor, and how staff should support this. Care plans were in partly pictorial format, including advanced care plans in relation to people's end of life care wishes, which were also in symbol picture format. A relative told us, "They [staff] can communicate with [Name of person] better than I can, because they sign and I can't do signing and am not there all of the time, but the staff are, so they know what [Name] is trying to tell them and they can use signs."

Relatives we spoke with told us they were able to visit any time. They told us, "You get a very warm welcome when you go" and "I can turn up any time [my relative] wants. The staff are always welcoming." Relatives also felt they were kept fully informed of any significant changes or issues in relation to their relative, and had regular contact with staff. One told us, "We've always had a close relationship [person who used service and their relative], and the staff know that, so are supportive of this and keep me fully informed." This showed us that the registered provider encouraged people to maintain positive relationships with their loved ones and involved relatives in the person's care where appropriate.

Good

Is the service responsive?

Our findings

Care was based on people's assessed needs and preferences. We saw evidence that before people moved into a flat at The Gables they had a number of introductory visits to the service, to spend time getting to know other people and for the registered provider to assess compatibility and whether the service could meet the person's needs. The registered provider completed a baseline assessment of people's needs, which covered a range of areas including medical and healthcare needs, personal care needs, communication, dietary requirements, privacy dignity and respect, mobility, employment and leisure activities, finances, transport and important people in that person's life. This assessment prompted staff to ask the person a range of questions in order to build up person-centred information about them. There was also a list of additional assessments that staff could use where relevant to the individual, such as memory, feeding, sleep and restraint plans. Staff were not required to use physical restraint with anybody who used the service at the time of our inspection.

The assessment formed the basis of each person's care plan. We found these were detailed and contained information on how people wanted to be supported. An 'independence supplement' document also contained specific details of the support required with meals, shopping, household budgeting, community activities, use of public services and facilities, use of appliances and social skills. Care plans were reviewed six-monthly, or sooner if required, to ensure they reflected people's current needs preferences. Relatives and people who used the service told us they were involved in these reviews.

This showed us that staff had the information they needed to provide personalised care to people.

The staff we spoke with demonstrated a good level of knowledge about people's individual preferences and needs, and relatives we spoke with told us that staff knew their relative well and treated people as individuals. Records, such as epilepsy, weight and behaviour monitoring charts, as well as daily support records, showed us that people's care and well-being was monitored. A daily file also included people's individual goals, with details of any activities they had undertaken towards achieving that goal. For instance, one person's goal was to increase their confidence with shopping, and there was a log of activity showing how they were working on this.

People who used the service attended day services or work related activities, most week days. In the evenings and weekends staff supported people to access a range of other leisure opportunities, such as clubs, shopping, football and rugby games and pub lunches. On the evening of our inspection we saw that a group of people were supported to go to a weekly social club.

One person told us, "I go to a 'knit and natter' group once a month. I go to craft every Monday, Thursday and Friday, and we go for meals on a weekend. Hopefully we're going to see the Blackpool lights soon." Others told us, "I'm going to see my girlfriend tonight at the Gateway club. I see her on Mondays too" and "I work at the horticulture centre."

Relatives told us, "[Name] has a very good social calendar and goes out at least four times a week" and

"[Name] has done all sorts over the years. [Name] doesn't always want to join in everything…but the opportunities are certainly there." Others told us, "[My relative] has a season ticket to the football and staff take him" and, in response to the question of whether their relative was supported to pursue any social or occupational activities, one relative told us "Absolutely definitely! [Name] was out when I called them on Saturday, and when I called them back on the Sunday they told me they'd been out at the wrestling!"

This showed us that people received personalised care that was responsive to their needs and there were a range of activities available to people.

There was a complaints procedure in place and a system to record and respond to complaints. Records showed that no complaints had been received in the year prior to our inspection, but people and relatives told us they knew how to raise a complaint or concern, and would feel comfortable doing so if they had any. Comments from people included, "I would speak to my keyworker or [name of care staff]. I think they would sort it out for me" and "I would let them know. I would speak to [manager] or if they are not in I would speak to [names of three care staff given]" and "I would be happy to chat to staff if I wasn't happy with something."

We saw from minutes of residents meetings and review meetings that people had opportunity to share their views about their care and issues at the home. Minutes of residents meetings showed that topics discussed included holiday ideas, staffing, activities and any concerns. People were also asked if they were happy with the care they received. Residents meetings were held every three months. People told us, "At our meetings we talk about things like security; what would you do if someone walked into the building? You need to ask to see their identity card. We also talk about what we want on the menu. You can ask for different things if you don't like something." We were told that at people's individual care review meetings relatives and people who used the service were given a satisfaction survey. People did not always choose to fill this in at every six-monthly review, but we saw examples where people had filled these in. Feedback was generally very positive.

This showed us that people's views and opinions were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

The service did not have a registered manager, but there was a manager who had been in post since January 2016 and their application to the Care Quality Commission to become the registered manager was being processed. The manager understood their role and responsibilities. There was also a senior support worker at the service, who provided leadership in the absence of the manager.

When we spoke with people about the management of the service the feedback was positive. People who used the service told us, "[Name] is the manager, I would be able to talk to them," "[Name] is the boss. Oh she's lovely. She's always giggling" and "She's been nice since she came here."

When we asked relatives if they felt the service was well-led they told us, "It seems to be well-led and organised," "[Manager] is excellent. They are approachable," and "[Manager] is on the ball." One relative told us, "There may be ways they do things differently to how I would do them, but [my relative] is very happy and settled here, so they must be doing something right!" Another said the manager had taken time to get "Fully up to speed with one or two aspects of [my relative]'s care, but they are getting there now… They are approachable and their actions have shown that they are addressing things."

Comments from staff included, "[The leadership] is very good and the manager is approachable" and "The manager has to split their time, but it's okay. [Senior support worker] is very good. I get enough support, and if you request stuff you get it." Comments from staff also demonstrated a positive culture and team approach; for instance, "It's a small staff team, we know each other… [The culture of the organisation] is forward thinking. There is a diversity of homes. It's as good as any I've worked for, if not better." Other staff told us the culture of the organisation and staff morale were very positive. One staff member said the values of the organisation were to, "Put the resident first and give them the care they need." Another told us that the organisation "Takes the service users and us [staff] into consideration. They are quite strict with things, like policies, training and staff expectations. The area manager and chief executive know the people individually and staff. They ask about our families for instance, so even though it's quite a large company there's a personal touch."

The manager told us they kept up to date with best practice and legislation by attending monthly events run by the council, such as a recent session about dementia. They also attended regular manager's meetings run by the registered provider, and networking events, including one about easy read documentation and the accessibility standard. Key information about best practice and changes in legislation were shared with staff in team meetings and supervision.

The registered provider sought feedback about the quality of the service, by offering people who used the service and their relatives the opportunity to complete a satisfaction survey at the end of each six-monthly review meeting. Responses to surveys were analysed and appropriate responsive action taken where required.

People and relatives expressed satisfaction with the quality of the service provided. Relatives told us, "I think

[the care] is very good," "We're very happy with [Name]'s care" and "[Name] is well looked after." Other comments included, "I'm mostly happy with the care [Name] receives" and "I have no concerns at all with the care [my relative] receives. It's a very good service."

The service had systems in place to audit the quality of the care they provided to people. As well as the satisfaction surveys conducted, the manager completed a range of audits. The area manager conducted quarterly health and safety audits, which included equipment, medication, staff and service user meetings, cleaning schedules, water checks, fridge and freezer and file checks. The service co-ordinator also completed monthly audits, covering various aspects of care and administration, including updates about individual people's care and support. We found audits had led to improvements being made. For instance, there was an action identified in the health and safety audit to defrost the freezer and give advice to staff regarding the labelling of food. We looked at the freezer and found that action had been taken to defrost it. We also saw in the staff communication diary that there was a reminder to staff that the 'use by' dates on food in the fridge were to be checked twice daily. The manager advised us that one outstanding action in relation to a broken fridge in the communal kitchen was being addressed. We also found that an action identified in a health and safety audit had resulted in all staff being required to practice using the fire alarms systems, in order to improve staff knowledge about operating the fire safety systems. The registered provider had a recognised quality assurance scheme; ISO 9001. The ISO 9001 is a best practice framework used to encourage best practice within businesses and improve performance.

This showed us that systems were in place to monitor and review the delivery of care and the quality of service that people received.

Policies and procedures were in place, and based on up to date legislation and guidance. We asked for a variety of records and documents during our inspection. Overall we found these were well kept, easily accessible and stored securely.