St Anne's Community Services

St Anne's Community Services - Jenkin Lodge

Inspection report

Jenkin Lodge
New Road, Ingleton
Carnforth
Lancashire
LA6 3JL

Tel: 01524241745
Website: www.stannes.org.uk

Date of inspection visit:
29 February 2016

Date of publication:
14 April 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 29 February 2016. The provider did not know we were coming. The service was last inspected in August 2014 and it was meeting all the regulations in force at that time.

St Anne's Community Services – Jenkin Lodge is a purpose built service which provides residential and personal care. The service is registered to support people with a learning disability. It does not provide nursing care. There were 5 people living there at the time of this inspection.

The service had a registered manager who had been in post since 2009 and had been registered in 2013. 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.

Staff had been trained to recognise and respond to any safeguarding issues. Staff knowledge and understanding of safeguarding was good. The service acted appropriately in reporting such issues to the local safeguarding adults unit. Relatives told us they felt their family members were safe when their support workers were providing them with support.

Risks to people were assessed, and risk assessments gave detailed information to ensure that people could be supported safely by staff. These had been reviewed consistently. Plans were in place to keep people safe in the event of an emergency. Accidents and incidents were fully recorded and were discussed at meetings to consider ways to ensure there was no reoccurrence.

There were a small amount of vacant staffing hours but there was a regular and consistent staff team. Staff files showed that recruitment was professional and robust to ensure suitable applicants were employed.

Medicine administration was managed and carried out appropriately and all staff had received training. Medicine storage was safe and appropriate. People were well supported with their nutritional needs and with their general health needs.

Staff had received training to enable them to meet people's needs. Staff had supervision and annual appraisal and this was completed in line with the providers own policy. Records of supervision demonstrated two way conversations between staff and the registered manager. Relatives told us they felt staff had the skills they needed.

People were asked to give their consent to their care. Where people were not able to give informed consent, their rights under the Mental Capacity Act 2005 were monitored. Staff knowledge of mental capacity and deprivation of liberty was good.

Families we spoke with gave us very positive feedback about the service and were very happy with the care and support their relatives received. We observed and relatives told us that staff were caring and knew people well. Relatives felt that their family members were cared for very well and were happy with all aspects of their care. Staff showed a good understanding of the importance of dignity, privacy and respect.

Care plans were clear and detailed, and reflected people's preferences. They were extremely personalised and demonstrated input from relevant others. Reviews and updates were recorded clearly. There were a good range of personalised activities and interventions offered to people on a daily basis.

The environment was in good condition with only one minor repair required. Infection control was well managed and staff demonstrated an understanding of ways to minimise the risk of infection.

There was regular engagement with families for both individual input to the person's support as well as development of the service. There was very positive staff morale across the staff team and a real sense of teamwork was evident throughout the inspection and in the conversations we had with staff. Staff felt the registered manager was extremely effective.

The registered manager was open to improvements to the service. There were systems in place to monitor the performance of the service and these were being used effectively to make improvements across all areas of the service provided. People told us they felt they were listened to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained to recognise and respond to any suspicion of abuse. Safeguarding procedures had been followed and staff showed a good understanding of safeguarding principles and processes.

Risks to people receiving a service were sufficiently assessed to ensure steps were taken to keep people safe from harm.

People received appropriate support to take their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had been given the training they needed to meet people's needs effectively.

Staff were given support to carry out their duties by means of regular supervision and appraisal.

People's rights under the Mental Capacity Act 2005 were respected and staff understanding was good.

People's health needs were assessed and met.

Is the service caring?

Good

The service was caring.

People told us their care workers were kind and caring, and treated them with respect.

People's privacy and dignity was respected and protected.

Is the service responsive?

Good

The service was very responsive.

People and their families were involved in assessing their needs and in deciding how they wanted those needs to be met.

People's care was very person-centred.

The service had responded to meeting people's needs in an effective and pro-active way.

Is the service well-led?

Good

The service was very well led.

Staff and relatives felt listened to and told us the registered manager was very good. Team morale was very high.

There were systems in place to capture the views of people, their relatives and staff.

There were systems to monitor the quality of the service and these were being used effectively.

St Anne's Community Services - Jenkin Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 29 February 2016. The provider did not know we were coming.

The inspection team was made up of one adult social care inspector.

We reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities to gain their experiences of the service. No concerns were shared with us prior to the inspection.

We spoke with the registered manager and three support workers. We were not able to speak with people who used the service as most did not have verbal communication. We spent time observing the care and support being delivered. We spoke with three relatives. We reviewed a sample of two people's care records; three staff personnel files; five medication records; supervision records for three staff; training records for all staff; and other records relating to the management of the service including maintenance, audits, policies and procedures and governance.

We looked at all areas of the home including the lounge, dining room, kitchen, laundry room, sensory room, bathrooms and with permission, some people's bedrooms.

Good

Is the service safe?

Our findings

We spoke with people's relatives about the care that people received. Relatives comments included, "They are definitely safe" and "I have absolutely no qualms about the care received".

We looked at how the service protected people from harm or abuse. There was a safeguarding policy in place which had been regularly reviewed. The policy included the principles of abuse, prevention, accountability and the process to follow when raising an alert. There was also a copy of the local multi-agency policy and procedure for staff to refer to. The registered manager and staff we spoke with had a very good understanding of what constituted abuse and the actions they should take. All the staff we spoke with were aware of the local safeguarding procedures and ways they could escalate any concerns they had. One staff member told us "I would report any issues to the manager or someone in senior management. I would document everything and act to protect the person".

There were safeguarding incident and protection plans in the files we looked at. These included some background, context of the issue and input from professionals such as occupational therapy, community learning disability team, a psychiatrist and family members. These included clear guidelines for staff about the current situation and the things leading up to these identified risks. Within care plans we also saw that risks were clearly identified but risk minimisation was balanced with personal choice. There were risk assessments where required for areas such as moving and handling, developing pressure areas, unsettled behaviour and medicines. These were detailed and gave staff clear directions on the triggers and ways to minimise the identified risks.

Safeguarding awareness was included as part of the induction for new staff. Training records we looked at confirmed all staff had completed safeguarding training. We discussed 'whistlebowing' with staff. They were fully aware of their responsibilities to report bad practice and all said they would report to the registered manager if they had any concerns. All of them told us they felt confident that the registered manager would take the appropriate action.

There were service risk assessments in place for areas such as the boiler installation, use of equipment, intruders, the environment, infection control, information governance and injuries to staff. These noted the hazard, the associated risk, any persons affected, existing controls, additional risk reduction and measures to be taken. A risk rating was applied and the level of information was good.

We looked at the records of accidents and incidents that had occurred in the service. Those recorded were fully documented and actions taken were recorded. The forms showed that staff had taken appropriate action and were extremely observant to the individual communication of people regarding pain. The registered manager told us, and we saw in meeting minutes that any incidents were discussed with staff and ways to minimise risks were considered.

The registered manager told us that staffing levels were primarily based on the needs of people using the service. People were supported 24 hours per day. There was a small team of permanent staff and the

registered manager confirmed that extra cover was provided by regular bank staff who knew people well. We looked at rotas for the five weeks following the inspection and the four weeks before the inspection. We found that there were between two and three staff working at all times. Staffing numbers were variable according to the activities that people were due to undertake and any appointments people required support to attend. The registered manager was usually supernumerary to core staffing numbers. They explained that this meant they were able to complete managerial duties and help out with the day to day running of the service. None of the staff or relatives we spoke with felt there were any issues with staffing levels and all told us that people received the support they needed in a safe way.

The service had systems in place to make sure only suitable applicants were employed to work with vulnerable people. These included checks of identity, any criminal convictions and work permits, taking up references from recent employers and asking for a full employment history. Interviews were recorded in good detail. This ensured that the provider made robust recruitment decisions.

We found there were emergency plans in place for things such as severe weather, evacuation and flooding. These had all been reviewed recently. There was a list of emergency contacts for staff to use in the event of different emergencies and a business continuity plan which ensured that staff would be clear what to do in the event of an emergency. Personal Emergency Evacuation Plans (PEEPs) were in place for everyone using the service. These were detailed and up to date according to people's individual needs.

A fire manual included information about the house layout, checklists for staff, a record of incidents and drills and records of equipment checks. Emergency lighting and alarm servicing was fully recorded and up to date. There was a service wide evacuation plan and associated risk assessments for any environmental hazards.

We looked at some of the other health and safety checks carried out in the service which included a monthly audit of the environment. These recorded what actions were needed and when these actions had been completed. Two of the three actions highlighted in the last audit had already been completed. Monthly checks of temperatures were fully recorded and were up to date. Water hygiene checks were carried out by an external provider and were up to date. Tests for legionella were also carried out. A file recorded the details of chemicals used in the service including contact numbers for the manufacturers and risk assessments for their use. This meant there were clear guidelines and checks in place to minimise any risks within the environment.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. We checked the stocks of medicines for four people and found these tallied accurately with the medicines records. Medicines records included individual profiles which were detailed and accurate and supported the safe administration of medicines. Where people were prescribed medicine on an 'as and when required' basis, the medicine file included detailed information about when the medicine should be used and other alternative actions staff could take before administering. Staff we spoke with told us they were trained in handling medicines and training records confirmed this. Competency checks were also carried out and recorded on a regular basis. There was a clear protocol in place which covered administering, collecting medicines, replacing dropped or damaged medicines, refusal and errors.

Medicines were given as prescribed and at the correct time. A staff member told us medicines were given on an individual basis at the times required rather than as part of a medicines round, to ensure that medicines administration met people's individual needs. We observed two people being supported with their medicines and this was done in a respectful and caring way. When we spoke with relatives they told us that

staff were very professional in their approach to medicines and were vigilant in managing people's health. We saw that people's care plans recorded clearly whether people had any preferences for receiving medicines.

During the inspection we looked round all the communal areas of the service and with permission, some people's bedrooms. The communal areas were well decorated and furnished. There was a minor repair needed in the kitchen as the worktops were stained and pitted and were therefore not meeting infection control standards. The registered manager had reported this to the internal maintenance provider.

All the communal areas were clean, as were the toilets and bathrooms. The registered manager explained that the cleaning was the responsibility of all staff. There was a checklist of jobs to complete and staff explained that they also cleaned things when required and this worked well. We saw in records that checks were in place for things such as gas safety, electrical installation, fire safety systems and equipment.

Good

Is the service effective?

Our findings

We spoke with relatives of people who used the service and they told us that there was a consistent staff team and that staff knew people well. Relatives told us "The staff support [name] with what they are capable of", "They are very well looked after", "We are very pleased, they have such a nice home" and "The staff seem so well trained".

Three members of staff we spoke with told us about the wide range of training they had completed. One staff member told us "The training is good and could ask for anything specific and it would be provided". The registered manager provided us with an overview of all the training completed by the staff team. We also looked at three separate training records for members of staff. This included fire safety, food hygiene, manual handling, medicine administration, safeguarding, the Mental Capacity Act (2005) and deprivation of liberty, infection control, equality and diversity, diet and nutrition and health and safety. Individual records showed that service specific training had also been completed for dementia, learning disabilities, mental health and communication skills. All staff had completed the range of training. There was a staff development plan in place that noted all training, when it had last been completed and when it was due to be refreshed. The registered manager explained that the deputy manager took responsibility for monitoring this and arranged for staff to attend training which was provided through the wider provider organisation. There were also records of competency checks in staff files including medication, fire safety and management and leadership. This demonstrated that staff were well trained and competent in their roles.

For newer members of staff their files included an induction record which showed how staff were supported when they started working in the service. A checklist showed the induction covered an introduction to the organisation, working with people, personal and professional development, policies and procedures, health and safety and communication. A workbook recorded evidence of staff demonstrating understanding of each topic. Staff undertook a probationary period. We saw that supervision recorded reviews of staff probation. These included areas of strength, areas for development, objectives for the next review and learning and development. The final probationary review included views of the staff member and the registered manager and a general overview of the first six months of employment. Staff also told us that they were given the chance to read care plans and speak with experienced staff about the care they were delivering before carrying out any support.

The provider had a programme in place for supervision and appraisal of staff. When we looked in staff files we found that these had been carried out on a regular basis, usually around every two months. Forms had been completed by the registered manager and showed that conversations were varied, constructive and included the point of view of the staff member. We saw that subjects discussed included role and responsibilities, performance, team working, training, and health and wellbeing. The registered manager clearly recorded where the staff member had achieved and objective or completed a positive piece of work. When we spoke with staff they felt these were very helpful and supportive discussions and they told us they felt able to raise issues during these meetings with the registered manager. The registered manager felt that these were a good opportunity to speak with staff about their performance and any professional development. Appraisals had been undertaken. These included a discussion regarding relationships,

performance, training, using initiative, challenges, learning and development and both person centred and organisational aims.

All the staff we spoke with told us they felt communication was very effective. Staff we spoke with felt that everyone knew what they needed to do on each shift and that this was primarily based on the needs of each individual. There was a handover which included a record of medicines administered, documentation completed, tasks undertaken, appointments, any nightly duties and any other information that needed passing on to the next shift of staff. Where there were any changes to policy or any areas where staff needed to be updated, these were kept in a 'memo file' which staff were required to check at the beginning of their shift. Where a policy had changed, staff were required to sign to say they had read the updated policy. These included team briefings, notes from the provider and relevant papers such as a local authority paper regarding people with learning disabilities accessing health services.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager confirmed that where people were subject to a deprivation of liberty, this was clearly recorded in their file and the appropriate authorisation was in place. We saw that the applications had been completed in great detail and had been authorised by the local authority. All the care staff we spoke with showed good understanding of what a Deprivation of Liberty Safeguard was and were aware of where these were active. All the staff we spoke with understood and were able to tell us how they supported people while maintaining their independence and safety as much as possible. They were able to clearly demonstrate that the care being delivered was in line with the authorisation in place.

Mental capacity assessments had been completed and agreement with care plans and support had been recorded. Where people did not have capacity, best interests meeting had been held. Best interest decision making is required to ensure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. The best interest meeting records showed that the appropriate people had been involved and the process had been followed correctly.

The registered manager and staff we spoke with had a very good understanding of the principles of mental capacity, human rights and equality. All those we spoke with were able to tell us about mental capacity and the processes that should be followed if there was any concern about someone's ability to make a decision. Staff were clear about best interests processes that might need to be followed and how this all influenced the ways they supported people in the service.

We checked how the service met people's nutritional needs and found that people had sufficient food and drink to meet their needs. People required different levels of support with preparing and eating food. People made independent choices where possible in relation to what they wished to eat for lunch and staff assisted where required. The lunchtime meal choices included a variety of options dependant on people's preferences and needs. The evening meal was usually a hot cooked meal. People who used the service had input into what was on the rolling menu by expressing their likes and dislikes. Staff noted whether people

had eaten a large amount of the food and whether they had expressed a like or dislike of it by recording a score for each person at each meal. This allowed staff to plan menus that were in line with people's preferences. Staff explained that the menu was updated and changed on a fairly regular basis. Where people had specific nutritional needs, these were catered for. We observed people being supported to eat appropriately where required. Where needed, people's weight was monitored and recorded in their care plan files.

There was a correspondence file for each person. These included details of referrals made to external professional services. Health needs of people were well recorded. Information was available in the records to show the contact details of any other professionals who may also be involved in their care. Care records showed that people had access to a General Practitioner (GP), district nurse, psychiatry, occupational therapist, dentist, chiropodist, speech and language therapist and other health professionals. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. We confirmed through speaking with staff, people who used the service and relatives that healthcare was well monitored and managed. Records were extensive and demonstrated there was good communication and a responsive nature to any advice given. All the files we looked at included a health action plan. This included information about the person to be used if they were, for example, admitted to hospital. This information was thorough and person centred and included guidance on how the person preferred to be supported and any needs they had.

Good

Is the service caring?

Our findings

Relatives gave us very positive feedback about the staff who worked in the service. One relative told us "Yes they are definitely very caring. [Name] is cared for". Another relative said "There is a difference in my relative's personality since being in the service. They are so much happier now. The staff speak about them like they are a person not a nuisance". Other comments included "Oh we are very involved. We go to meetings. It is very helpful", "The staff, they really care" and "They give [name] dignity and confidence".

We spent time during the inspection observing interactions between people and staff. We found that all interactions were positive and it was clear that staff knew people well. There was some jovial interactions and people clearly enjoyed the company of staff. Staff took time to chat with people and responded to requests for support in a timely manner. We observed that staff always took the opportunity to socially interact or instigate activities with people during times when no care tasks were being completed. Staff ensured that they adapted their communication style to each individual and used touch and other non-verbal techniques to stimulate interactions and introduce tasks.

A sensory room had been designed by staff. This included bean bags, comfy chairs, light equipment and sound equipment. The room was decorated with sensory wallpaper and had black out blinds at the window. Two people used the room for both intensive interaction and as a relaxed and quiet area. A projector allowed films and videos to be projected on the walls. We saw that the space was used flexibly throughout our inspection. Staff told us that the serene space had enabled people to calm down at times of agitation which proved useful when other distraction and de-escalation techniques had not been successful. We observed that staff spent time with people using the room. We saw intensive interactions being undertaken on several occasions as well as chatting and quiet singing with people. People clearly enjoyed the time they spent in the sensory room.

Bedrooms had been personalised to each individual and staff explained the ways that they had involved people in making decisions and identifying things that would make the space more inviting and personalised to the person's preferences.

Within care plans we saw detailed records relating to communication and areas such as intensive interaction. One record we looked at said '(Name) needs physical contact, rhythmical patterns and two way interactions. This will help to build capacity to interact'. Records also showed complex planning for carrying out simple tasks with a focus on developing independence where possible. An example was in one plan where guidance was given for supporting a person when brushing their teeth, eating at the dining table and when the person was frustrated about something. The plans were very focussed on the person's needs and how staff should respond, what the triggers might be and ways to de-escalate if it was needed. The language used was respectful and caring.

Care plans were structured as morning and evening routines which gave clear instructions but encouraged independence throughout. Activities, communication and contact with family and friends were included in the plans for each person. Communication plans showed staff how to interpret non-verbal cues for consent

to support. In one file for a person we saw a communication contract that instructed staff about the importance of acting consistently, interpreting non-verbal communication and assessing expressive skills. Topics covered how the person would tell you when they were feeling something, what they might say, what vocalisation they might use, if they used any signs such as facial expressions, eye contact, body language and movement of hands and feet.

We observed throughout the two days of the inspection that people were supported to go out into the community. Most of the people who used the service were unable to verbally communicate. However, work had been done with each person to identify things they enjoyed doing. In some cases this had been through trying different activities and gauging the person's response. This information would then be shared and discussed with the staff team and families to consider what else could be added on to the person's activity schedule. When we spoke with staff they were able to tell us the variety of different things each person enjoyed and didn't like doing.

We observed throughout our inspection that where possible, people were able to make decisions about what they wanted to do, where they wanted to spend time and the things they engaged in. We saw that some people enjoyed spending time in their rooms listening to music or in the communal areas if they wished. Staff ensured that people were where they wanted to be and that they were comfortable. Staff were calm and quiet and supported people in a gentle manner.

One person whose file we looked at had a daytime activities planner. This was an activity chart that staff used to let the person know what they were going to be doing each day. It included visiting family and activities both inside and outside the house. Staff explained that the person could sometime get anxious about when things were happening and the use of the chart had helped to alleviate some of this anxiety. The chart was part of establishing a clear routine for the person as they were generally more settled if they had a regular routine. Staff understood the importance of this.

People had specific care plans regarding personal wellbeing. These covered dignity, respect, mental and emotional wellbeing, protection from harm, control, participation, social wellbeing, domestic and family relationships, and contribution to society. Each area had specific actions noted and how the area was to be monitored. Where appropriate, care tasks specified if they should be carried out by male or female staff to protect people's dignity. Staff we spoke with had good knowledge of how to support people while maintaining their privacy and dignity. We saw that this was demonstrated with the care being delivered during our inspection. Plans demonstrated that families and people where possible had been involved in their development and review.

We observed that staff respected people's privacy and provided them with support and personal care in the privacy of their own rooms. We saw staff knocked on a person's door and waited for permission before they went into their room.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager any issues or concerns. One person who used the service had an independent advocate who worked with them on a regular basis. An advocate is a person who supports the person to have an independent voice if they do not have family or friends to advocate for them.

Some people had sections in their care plans that documented any end of life wishes they or their families had. These had been put together with the involvement of families where appropriate.

Good

Is the service responsive?

Our findings

People's relatives told us that they felt staff were responsive to their needs. Comments included "They went to the hospital with them and stayed there with us", "They keep us up to date", "There is always someone on hand, the staff look after them".

We observed during the inspection that staff were responsive to people when they required support and they offered and prompted assistance when they thought it might be required. We saw staff pro-actively engaging people in activities or general conversation and when people required assistance, such as with personal care, this was delivered in a timely manner.

We looked at care plans for two people who used the service. Care plans were very well structured and included individual plans covering a range of topics including morning and night time routines, personal care, dietary needs, medicines, medical conditions, personal wellbeing, mobility, sleep patterns and finances. There was evidence that care plans were written with the involvement of relatives and people. All of the care plans had been reviewed and changes made as necessary. A list at the front of each of the folders documented when each care plan had been reviewed and updated and what sections had been changed. These had been completed either once every six months or when the needs of the person changed. One or more of the plans were reviewed per month. The care plans were very detailed, person centred and included a good level of information for staff to use to direct the support in the ways people wanted.

We saw that usually before a person came into the service an assessment of needs was carried out. This assessment covered all the appropriate areas and was completed to a good level of detail. This ensured that the service was clear on the needs of the person and how they would be able to support them prior to the person moving into the service. We also saw that where the service had needed to admit a person in an emergency, they had arranged this particularly well. There had been limited information provided prior to the person arriving and the service had only had a short period to prepare. Despite this, the staff and registered manager had undertaken extensive work when the person had arrived and since to build a complete picture of the support the person needed. They had researched and contacted previous providers and involved professionals to gather information. The staff had also spent a large amount of time working directly with the person to ensure that the care they were providing met the person's needs and was in line with their preferences. They had demonstrated excellent responsiveness in meeting the needs of the person and as a result the person was now much more settled than they had been previously.

When we spoke with the registered manager they told us that this had been challenging and they were still working to develop the person's care and approaches to support. They felt that the dedication and consistency of the staff team had enabled the transition to be as smooth as it could. The registered manager also talked openly about the lessons that had been learned from the situation and the things they would do differently if a similar situation arose. This showed that there had been some reflection on the response the service had provided to an extreme situation.

We looked at the information regarding complaints. A policy was in place which included the process to be

followed for both complaints and compliments. Five compliments had been recorded including three from external professionals. No complaints had been received in the time since our last inspection. The registered manager explained how complaints would be dealt with including investigating and responding quickly, apologising if mistakes had been made, and learning from any feedback to ensure that improvements were made.

Good

Is the service well-led?

Our findings

A registered manager was in place who had been working at the service since 2009 and had been registered in 2013.

Relatives were very complimentary about the registered manager and the service overall with comments including "I can ring the manager any time", "I would raise concerns if I had any and I am sure they would do something", "10 out of 10. I give them that score" and "I am definitely happy with the manager".

Staff were also complimentary of the support offered by the manager. Comments made to us included "The manager is very supportive", "There is a very good team, with good values. We all try to the best of our ability. The manager is good, he listens and I feel I can ask for advice", "I enjoy my job and I find the manager understanding. I could discuss concerns with them or my colleagues" and "I feel well managed, I feel safe and can talk to the manager. We have a brilliant staff team". Staff agreed that the manager ran the service very well. Staff felt that suggestions and ideas were implemented by the manager when made by staff. The registered manager told us that they felt it was vital to involve staff in developing and improving the service.

There were a wide range of systems being used to monitor and improve the service to ensure it was effective and high quality. There were also quality assurance processes in place which had been used consistently. A monthly audit file showed that finances, mental capacity act assessments and deprivation of liberty authorisations, infection control, staff training, health and safety, nutrition, community participation, care plans, risk assessments, safeguarding, medicines, fire safety, information governance and service vehicles were all subject to regular checks and audits.

The registered manager told us, and documents we looked at demonstrated that a series of interventions and checks were undertaken to assess the quality of the service. The area manager visited monthly to carry out an audit of several different areas, alternating at each one and always inclusive of interaction or observation of people using the service. Monthly managers meetings enabled managers from the local area to get together and discuss issues, concerns or matters arising. The registered manager had attended workshops to consider how to deal with complaints and compliments, professional development of staff and effective supervision, and health and safety checks. The registered manager explained how all these things together with client involvement were utilised to gather feedback on the quality of the service. Because of the communication needs of people using the service, this was done by finding individualised approaches to communication and daily interaction and monitoring of people's satisfaction levels.

There were timetables in place for the review of care plans as well as the keyworker tasks undertaken and the activities undertaken by people using the service. Recruitment and staff development was also regularly reviewed by the registered manager. Questionnaires were sent to people and families but the registered manager explained that these were now co-ordinated and analysed centrally and the results had not yet been sent out for the most recent survey.

A contract monitoring visit had recently been carried out by the local authority. This had been a positive visit

with multiple good practice points highlighted including documentation and management of the service. A quality document the provider had implemented included a wellbeing outcome framework and basic standards expected in the service. This demonstrated that the focus was on continuous improvement in areas such as meeting individual's physical, emotional, social and cultural wellbeing. It noted how success was measured through both internal and external monitoring. Aims for the service covered various areas, for example communication, privacy, cultural needs, participation, relationships and living conditions. The registered manager explained that this document was the basis of the quality improvement framework used in the service.

A management structure chart clearly defined the roles of each member of staff in the service. There was also clear guidance for staff on expectations around completion of notes, procedures to follow in an emergency or following an incident and what to do if staff cover was required.

A strategic plan for the period 2014 to 2020 had been put together by the wider provider organisation. This included details on how improvements were going to be made and the areas that were to be the focus of the organisation such as 'clients at the centre' and 'learning and development'. The vision, mission, principles, key achievements, themes and strategic aims were all included.

We saw evidence and staff told us that staff meetings took place on a regular basis. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed these had been held on a regular basis. The registered manager and staff had discussed topics including medicines, incidents, pharmacy, telecare, individual issues with people who used the service, environment, learning and development, audits, dignity and duty of candour. We saw from the minutes that these extremely constructive and inclusive conversations. This was particularly the case when discussing incidents. Ideas and suggestions from all staff had been considered and these had been open and honest discussions.