Ultima Care Centres (No 1) Limited

Moorland Gardens Care Home

Inspection report

Moorland Garden Street
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection was carried out on 16 and 22 May 2018. This was the first inspection since the service was taken over by Ultima Care Centres (No 1) Limited.

Moorland Gardens Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 80 people with a range of care needs including those living with dementia, mental health needs and physical disabilities. The service also operates a short stay rehabilitation unit where people are admitted from hospital for rehabilitation of up to a period of six weeks. At the time of the inspection, 54 people were being supported by the service.

There was no registered manager in post as she deregistered in February 2018. Prior to this, the deputy manager had acted as the interim manager since August 2017. At the time of the inspection, the deputy manager was managing 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.

Changes in managers had an impact on the leadership of the service. This resulted in inconsistencies in the quality of care at the service. This was because systems to keep people safe from abuse or avoidable harm had not always been used effectively. Additionally, people's medicines were not always managed safely to provide effective treatment. However, we noted that the provider had put systems in place to support the service to improve and some improvements had been made at the time of the inspection. The provider's senior managers regularly supported the manager to assess and monitor the quality of the service.

There were effective recruitment processes in place and there was sufficient numbers of staff to support people safely. However, the manager needed to review how staff were deployed as some people said that there was not always enough staff.

The service was clean and pleasant for people to live in. Staff took appropriate precautions to ensure people were protected from the risk of acquired infections, and there was evidence of learning from incidents.

People's needs had been assessed and they had care plans that took account of their individual needs, preferences, and choices. Staff had regular supervision and they had been trained to meet people's individual needs effectively. The requirements of the Mental Capacity Act 2005 were being met, and staff understood their roles and responsibilities to seek people's consent prior to care and support being provided. People had been supported to have enough to eat and drink to maintain their health and wellbeing. They were also supported to access healthcare services when required.

People were supported by caring, friendly and respectful staff. They were supported to have choice and control of their lives, and the policies and systems in the service supported this practice.

Staff regularly reviewed the care provided to people with their input to ensure that this continued to meet their individual needs in a person-centred way. The provider had an effective system to handle complaints and concerns. Some activities were provided, but some people did not find these enough to occupy their time. The manager also needed to review how they supported people to pursue their hobbies and interests. People were supported in a dignified way at the end of their lives.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems to safeguard people from harm and abuse were not consistently followed. People's medicines were not always managed safely.

There were effective recruitment processes in place, but there was not always enough staff to support people safely and quickly.

Risks to people's health and wellbeing had been managed well. The service was clean and there were effective infection prevention systems in place.

Is the service effective?

Good

The service was effective.

People's care needs were appropriately assessed. Staff understood people's individual needs, and provided effective care and support.

Staff received regular training, supervision and support in order to support people effectively.

People's nutritional needs were met.

The requirements of the Mental Capacity Act 2005 were being met.

Is the service caring?

Good

The service was caring.

People were supported by kind, caring and friendly staff.

Staff respected people's choices and supported them to maintain their independence.

People were supported in a respectful manner that promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans to enable staff to provide person-centred care.

People's needs were met by responsive and attentive staff.

The provider had a system to manage people's complaints and concerns.

People were supported well at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There had not been a registered manager at the service since August 2017. This had an impact on the leadership of the service and subsequently, the quality and safety of care provided to people.

People, relatives and staff felt able to share their experiences of the service. They found recent improvements had been made.

The provider had put systems in place to assess and monitor the quality of the service. Their senior managers provided regular support to the manager.

The service worked closely with other stakeholders to learn and continually improve.

Moorland Gardens Care Home

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 checked 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.

The inspection was prompted in part by concerns relating to poor care and delays in reporting incidents that put people at risk of harm. There were also concerns about how people's medicines were managed, particularly in the Rehabilitation unit. This inspection examined those risks.

This comprehensive inspection took place on 16 and 22 May 2018. It was unannounced.

The inspection was carried out by an inspector and two experts by experience on the first day, and one inspector visited the service on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the service including notifications they had sent us. A notification is information about important events which the provider is required to send to us.

Prior to the inspection, we contacted the local authority that commissioned the service, the local Healthwatch and the local Clinical Commissioning Group. The local authority told us that when they inspected the service in April 2018, they found areas of improvement in relation to safeguarding people, consistency of good quality care, and management of the service. We looked into these issues when we

inspected the service.

During the inspection, we spoke with 15 people using the service, nine relatives, two nurses, seven care staff, an activities coordinator, two professionals working for the service that provided rehabilitation support and treatment to people in the Rehabilitation unit, the deputy manager who was the interim manager. We were supported over the two days by the provider's regional support manager. We also spoke with the provider's assistant director of quality and compliance who was doing an internal inspection on the first day of our inspection, and we met the provider's regional operations manager during the second day of the inspection.

We looked at the care records for eight people to review how their care was planned and managed. We reviewed the provider's staff recruitment, training and supervision processes. We checked how medicines and complaints were being managed. We looked at information on how the quality of the service was assessed and monitored. We observed how staff supported people in communal areas of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection, information shared with the Care Quality Commission about safeguarding incidents indicated potential concerns about staff's skills in identifying when people's health had deteriorated and taking prompt action to seek medical advice. The outcome of a safeguarding investigation in February 2018 also highlighted concerns about staff's safeguarding knowledge and their timeliness in reporting incidents. This information and concerns we received also indicated issues about how people's medicines were managed, with some people not consistently getting their medicines because they had run out.

During the inspection, we reviewed how the service dealt with potential safeguarding incidents and found there was guidance for staff on what to report and to whom. We found some of the delays in reporting incidents were because of some staff's misunderstanding that only senior staff reported incidents to the local authority. To make the required improvements, the provider had ensured that all staff had up to date safeguarding training, and that all shift leaders had access to the paperwork necessary for them to report incidents in a timely way. There was also ongoing work to develop the nurses' competency to appropriately assess people's health and take prompt action to seek medical advice where required.

Staff we spoke with were knowledgeable about the provider's safeguarding policies and local reporting procedures. One member of staff told us, "I've done safeguarding training and I know what to do when I'm concerned about someone. I would normally report this to the nurses first and then the manager if nothing was done about it." Another member of staff said, "I have never been concerned about abuse here. I always tell the nurses about any incidents I see and they report it."

People we spoke with were happy with how staff supported them with their medicines. One person said, "I have no problem with my pills, they sort it all out. My pain pills are all sorted and I don't have any problems with it." However, concerns we received prior to the inspection indicated that people's medicines were not always managed effectively. There were systems in place for ordering, administration, recording, storing, auditing, and returning unrequired medicines to the pharmacy, but these were not always followed. For example, we saw that there had been a few incidents when people had run out of medicines, particularly in the Rehabilitation unit. We were also contacted by a person who raised concerns that they had run out of medicines a few times while in the Rehabilitation unit. They also told us that their pain relief medicines were not always given in a way that promoted effective treatment as they were at times, left in pain and unable to take further medicines until hours later. The clinical lead had now taken the lead role in ensuring that people's medicines were re-ordered in a timely way. As a result, there were no discrepancies between the records we looked at and stocks of medicines held by the service.

On the first day of our inspection, we observed that a nurse had not followed the provider's guidance for staff on how to manage medicines safely. This was because they administered a person's medicine without checking their medicines administration records (MAR) to ensure that they were giving them the right medicine and the right dose. This had the potential of putting the person at risk of harm and we noted that as a result, the provider took disciplinary action. Additionally, we saw that the manager and regional support manager had completed audits of medicine records and medicine stocks. Overall, they found these to be

managed well, and the MAR we looked at had been completed fully. Where recording issues had been identified, they had introduced a form that the member of staff responsible for the error completed to reflect on what went wrong and how they could improve. They told us this made staff pay more attention when managing medicines to ensure they completed all processes accurately and fully.

There were safe staff recruitment procedures in place. However, people told us there was not always sufficient staff to meet their individual care needs safely and in a timely way. One person said, "There aren't enough staff. The ones who are here work so hard all the time. There is just no let up and we still have to wait." Another person said, "I've waited a long time today for help to wash, they seem to be short again." One relative told us that there were many changes of staff which did not promote consistency of care, particularly for people living with dementia.

Staff told us they usually had enough of them on shift, but there were at times not enough staff due to unexpected absence. They however, explained that in such cases, they were either supported by staff from other units or the nurses helped more with supporting people with personal care. One member of staff said, "Supporting residents with personal care takes too long as five of them on this unit need to be supported by two staff. It's not easy if you have three staff on shift." Another member of staff said, "I can't say we can't cope, but we struggle sometimes. It is difficult to determine staffing numbers here (Rehabilitation unit) as residents change every week." They added, "When someone calls off sick, they need to always find a replacement as this makes everyone's work difficult. Sometimes we get help from other units."

Feedback from external professionals who provided treatment for people in the rehabilitation unit also indicated that there was not always enough staff to provide effective care. One example was that there were sometimes delays in supporting people with their physiotherapy or occupational therapy because they had not been supported with their personal care in time for them to attend planned treatment sessions. This had the potential of making people remain at the service longer than expected and improvements were required. We discussed these issues with the manager who showed us how they calculated the numbers of staff required to support people. However, they told us they would review this and how well staff were deployed around the service to ensure that people were supported safely and quickly.

People told us they felt safe living at the service. One person said, "I feel very safe here. We're alright here. It's nice to be looked after." Another person said, "I feel quite safe here, there is usually someone around." Relatives also told us their relatives were safe. One relative told us, "It's a lovely safe home for [relative] who came in on respite, but decided to stay."

Potential risks to people's health and wellbeing had been assessed. Care records showed that people had individual risk assessments for various issues including being supported to move, falling, eating and drinking, pressure damage to the skin, use of bedrails, behaviour that may challenge others, and specific health conditions. These and information contained in related care plans gave guidance to people and staff on how risks could be minimised. For example, a person admitted from hospital with moisture lesions had a monthly pressure sore assessment and their care plan detailed the skin care they needed to prevent further skin breakdown. Records showed that there was a system to review risk assessments regularly, and prompt action was taken to update these if people's needs changed. We saw that the manager reviewed accidents and incidents that occurred at the service so that they put systems in place to reduce the risk of them happening again.

Staff completed regular health and safety checks to ensure that care was provided in a safe environment. There was an environmental risk assessment to assess and mitigate any hazards that could put people, visitors and staff at risk of harm. The service was clean because there were dedicated staff for this role.

Cleaning schedules showed that all areas of the service were cleaned regularly to provide a safe and pleasant environment for people to live in. One relative told us, "Everything here is always clean, the cleaners are excellent."

People were supported in a way that ensured they were protected from risks of acquired infections, and people we spoke with confirmed this. Relatives told us that they always found the service clean when they visited and they saw that staff wore aprons and gloves when providing personal care. Staff told us they had adequate supplies of protective equipment such as gloves and aprons. We observed that they wore these when required. One member of staff told us they had supplies of special gloves due to their allergy to latex. There was infection prevention guidance for staff and they told us that they followed appropriate hand washing procedures to reduce the spread of infections.

Good

Is the service effective?

Our findings

People told us that staff were skilled and their care needs were met. One person told us, "We're well looked after and I'm happy here." Another person said, "I am looking forward to going home now, but the staff have been very helpful." Staff told us people received good care including one member of staff who said, "It's good to work in the same unit because we get to know the residents well and what care they need."

Records showed that staff had received a range of training for them to acquire skills and knowledge to support people effectively. Staff were complimentary about the quality of the training and support they received through regular supervision and appraisals. One member of staff said, "Training is okay. I come in on my off days and we get paid for this. I do online training too." Another member of staff told us, "Training is excellent. We have all the training we need. [Manager] comes around and we ask her or nurses for advice. Physios (physiotherapists) are always helpful and teach us sometimes."

Staff told us they had regular supervision which they found useful and positive. One member of staff said, "I had supervision with [manager] about a month ago and it was fine." This was evident in the records we saw.

People's care needs were assessed prior to them moving to the service. The service had a dedicated nurse assessor who visited people referred to them to assess if they could meet their care and treatment needs. Staff used the information gathered during these assessments to develop people's care plans. We saw that there were detailed care plans that took account of people's needs, choices, views and preferences. Care plans enabled staff to provide good quality care to people with a range of care needs including personal care, eating and drinking, medicines, support with mobility, and specific interventions to help people improve their health and independence.

People told us they enjoyed the food and they had enough to eat and drink. They were supported to choose what they wanted to eat and drink, and alternative food was provided if they did not like what was on the menu. One person said, "The food s alright." One relative told, "The food is good. There is a choice and plenty to eat. They ask people to decide what they want to eat on the morning of each day." Another relative said, "The food is ok. If anything, there is too much as [relative] has put on a lot of weight." While another relative told us, "We are so pleased with the staff here. When [relative] came in she was unable to eat, but the staff have really encouraged her and she is now eating well."

We observed that the food people ate was presented well and it looked well cooked and appetising. The service was part of the 'Hydration project', a local initiative led by the local authority and the local Clinical Commissioning Group to ensure that people were supported to drink enough. Each unit had entered a competition to decorate their hydration trolley to ensure that it was attractive so that this encouraged people to drink more. Some people and a relative told us that they had been involved in decorating the drinks trolleys. We found this was a good way of making sure that people had access to plenty fluids, fruits and snacks that increased their fluid intake throughout the day. Individual jugs of water also meant that staff could easily monitor how much people had drank.

People's weight was monitored regularly to ensure that they ate enough to maintain their health and wellbeing. Where required, staff monitored this closely by recording what people ate and drank. Staff were not concerned about people not eating and drinking enough, and they told us that prompt action was always taken when issues were identified. Where necessary, we saw that referrals had been made to dietitians and speech and language therapists to support people to eat well.

The service worked closely with various health professionals so that people received healthcare support when required, and people we spoke with confirmed this. One person said, "A doctor came every day at first because I needed extra help. Now it has settled, but we can still see the doctor when we need to." One relative told us, "The staff are very good here. When he (got injured, they called a doctor straight away and helped to stop the bleeding." We saw that GPs, chiropodists, opticians, dietitians and community nurses had been involved in providing care and treatment to people when required. Staff supported people to attend hospital appointments.

People's individual needs were met by the adaptation, design and decoration of the premises. For example, the corridors were wide enough for people using mobility aids to move around safely. The service had been decorated and it looked light and bright. However, it did not look homely in areas where pictures had not yet been hung. The provider's regional support manager told us of the plans to make the environment more homely, stimulating and interesting to live in. These included hanging pictures on the walls, and painting some areas with bright colours that would add interest for people.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was working within the principles of the MCA, and conditions on authorisations to deprive a person of their liberty were being met. Where required, mental capacity assessments had been carried out to ensure that decisions made on their behalf of people who lacked mental capacity were done in accordance with the law. Additionally, the manager had made referrals to relevant local authorities to ensure that any restrictive care was lawful. Some people had valid DoLS authorisations in place to ensure that they were supported in a safe way.

Staff had been trained on the MCA and they showed good knowledge of this so that people's rights and choices were protected. Consent to care was sought in line with legislation and guidance. We saw that some people were able to give verbal consent to their day-to-day care and support, and staff told us that they always asked for people's consent before care was provided.

Good

Is the service caring?

Our findings

People told us staff were kind, caring and friendly. One person told us, "The carers are lovely and very kind." Another person said, "The carers are really nice." A relative told us, "I think it's a very nice home, and the nursing staff are excellent."

Throughout the inspection, we observed positive interactions between people and staff. Staff always spoke with people whenever they came into the communal areas of the service in a pleasant and respectful manner. We also heard that staff were friendly and respectful when speaking with people in their bedrooms. People told us staff interacted with them whenever they could, including one person who told us, "Some of the carers are amazing, they are so busy but they do everything they can." We observed people chatting amongst each other in the lounges, and two people told us they had become friends since meeting at the service. A relative confirmed that staff encouraged people to socialise with others so that they did not become isolated and lonely. They said, "When [relative] first came she didn't want to go into the lounge, and stayed in her room. The staff encouraged her to socialise in the lounge, which she does and she enjoys it. What is nice is that she now chats with other residents, which the staff promote here. There's a nice atmosphere here."

People told us that staff asked for their views about how they would like to be supported, and that their preferences were respected. Staff confirmed this when they told us that they always actively involved people in making decisions and choices about their care and support. The examples they gave us of how they did this included: people choosing when they wanted to go to bed or wake up; what they wanted to wear; gender of the staff who supported them with personal care; food they ate; how they spent their day. Relatives told us they were encouraged to get involved in supporting their relatives to make decisions about their care. This included them being involved in the care planning and reviewing processes.

Some relatives told us they were supported to provide some care interventions to help their relatives in the rehabilitation unit recover quicker. One relative said, "The physio (physiotherapist) showed me what to do (massage) so that I can do it more times to help [relative] get better." Relatives also told us that the service understood the importance of people maintaining close relationships with their families and therefore, outside of mealtimes, there were no restrictions on visitors. However, the guidance on visiting times could be reviewed as required in individual cases. One relative said, "They knew [relative] needed me here, so they gave me permission to stay during the day because that's what [relative] needed."

People told us that staff supported them in a respectful manner, and they promoted their privacy and dignity, particularly when providing personal care. One person who told us that they normally experienced pain during personal care said, "The carers are always very kind and gentle with me." We observed that staff were respectful and discreet when asking people sitting in communal areas of the service if they wanted support with their personal care. We noted that staff also understood how to maintain confidentiality. They told us they did this by not discussing about people's care outside of work or with anyone not directly involved in their care. One member of staff told us, "I've seen everyone being respectful when talking to residents or supporting them with care. I would definitely be concerned if I saw a member of staff being rude

to residents and I would report it to the manager." Within all units of the service, we saw that people's care records were kept securely, in locked cupboards so that they could only be accessed by people authorised to do so.

People told us that staff encouraged them to maintain their independence as much as possible, and would only provide support when it was necessary. Some people were at the service for short periods of respite care or for rehabilitation, and they needed support to develop and maintain their independent living skills so that they could look after themselves when they returned to their homes. One person told us, "I completely rely on them to move me, but little else."

Good

Is the service responsive?

Our findings

People told us their individual needs were met in a person-centred way. They were aware that they had care plans that staff followed to ensure that their assessed needs were met effectively and in a responsive manner. Some people recalled being involved in planning and reviewing their care plans, but others were not able to give us this information due to their health conditions that affected their memory. Relatives we spoke with said they knew what their relatives needed care and support with, and they knew about their relatives' care plans. They also said that staff normally ensured that they were involved in their relatives' care by discussing any issues with them, and informing them in a timely way if their relatives' care needs changed. One relative said, "The staff all know [relative] really well. There is an emphasis on nursing care here and I'm very content with [relative] being here." Another relative said, "If ever anything (changes), we're always kept informed. [Relative] was upset and the manager phoned us up to tell us about it. It's nice to be kept informed."

We saw that staff worked closely with people and their relatives to regularly review the care plans to ensure that these continued to meet people's individual needs in a person-centred way. Care records showed that care plans were reviewed monthly or earlier if people's needs changed.

Some people said that they at times had to wait to be supported when staff were busy, but they always got the support they required to meet their needs. People and relatives told us that staff were responsive to people's individuality and preferences, and always planned care based on what each person needed. One relative told us that the service's routines could be changed in response to individual needs. They said, "They let us bring the dog in to see [relative]. We had to bring him downstairs, but it made him so happy." Another relative told us, "I am an exception being allowed to be here most of the day because [relative] wasn't doing well without me. I can have lunch here too for £1.50 if I want to. Usually visitors aren't allowed to come at lunchtime." The service had 'protected mealtimes' to enable people to eat without being disturbed. However, there was flexibility in this if it was deemed that people would benefit from their relatives supporting them to eat.

There were two activities coordinators employed to support people to occupy their time during the day. We observed some people taking part in activities during the two days at the service and people we spoke with confirmed that they took part in some of the activities. We saw an activities coordinator applying make-up to some of the people who wanted this; they played with musical instruments with some people or just chatted with others. Due to the nature of the service, some of the people were mainly cared for in bed and staff provided one to one contact with them in their bedrooms. For example, they completed word puzzles, played board games or read with those people. One person told us of some of the activities they had taken part in. They said, "We go out to the park and I like going to the park." One relative said, "Yesterday, some of them went to the park."

Some of the people and relatives felt that apart from large-scale events such as barbeques and fairs, there was not enough planned to occupy people on a day-to-day basis. One relative said, "There is definitely not enough for the residents to do, although they do play music which people like." The activities planner

showed that there were various planned events throughout the year including those facilitated by external entertainers. We observed that children from a local school came to sing on the evening of our first day of inspection and we were told that this was a regular arrangement as people enjoyed it.

We discussed with the manager how they would ensure that people had enough and interesting activities to take part in daily and they told us that they regularly reviewed the activities planner to ensure that a variety of activities were provided. They were also going to work closely with the activities coordinators to ensure that they facilitated activities that people wanted and enjoyed, and where possible, support people to pursue their hobbies and interests outside of the service. A member of staff told us that there were resources to enable them to buy materials to facilitate activities. They said, "The company is very good with budgets, and we also raise money through our garden fetes and raffles."

The provider had a complaints policy and procedure in place. People and relatives we spoke with knew how to raise concerns or complaints. Some people told us they had never complained because they were happy with how their care was managed. Those who had complained said that their concerns had been responded to in a sensitive way. We reviewed complaints that had been received by the service in the 12 months prior to the inspection and we saw that appropriate action had been taken to deal with these.

Many people were supported by the service at the end of their lives. People had end of life care plans in place, but we noted that the provider's own quality monitoring processes had identified that these needed to be more detailed so that people's views and preferences were appropriately recorded. None of the people and relatives we spoke with had concerns about the staff's ability to provide dignified end of life care.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post as they deregistered in February 2018. Prior to this, they had not managed the service since August 2017. The deputy manager had been acting as the interim manager during this period. There was an increase in concerns about the quality and safety of care at the service, and we were concerned that the changes in leadership of the service were affecting the consistence of care provided to people.

At the time of the inspection, the deputy manager was managing the service, but a decision had not yet been made if they would be registering with the Care Quality Commission. We discussed with the provider's senior staff that this situation needed to be resolved. They assured us that they were providing regular support to the manager and would ensure stable leadership was in place as soon as possible.

Some people and relatives did not know who the manager was. One person said, "I have no idea who the manger is." One relative said, "I don't know who it is. I think there have been a lot of changes." Another relative said, "I have no idea who it is. We only see the carers or sometimes the nurses." However, none of them raised concerns about how the service was managed, with one person and one relative telling us that they had seen improvements in the last few weeks. The relative said, "Things have improved in the last few weeks because the area manager has been around. That makes it so much better." Those people and relatives who knew the manager were complimentary about how supportive they were and that they showed compassion towards people using the service. One relative said, "There is an excellent manager here and we see her a lot. She is always observant and she ensures things are done in the proper manner. If she sees anything not quite right or not being done correctly, she's on top of it!" Another relative said, "[Relative] had her birthday and the manager allowed us to have the birthday party here in the home. There were balloons and flowers everywhere, and staff had a lovely party for her."

Staff were also complimentary about the manager and they felt supported in their roles. One member of staff said, "She is very good, and we've worked together for a long time." Another member of staff told us, "Everything is fine here and I would definitely recommend it to others. We work well as a team and relate well to each other. We are like a family and it makes the job easy. [Manager] is very supportive to everyone." Staff felt valued and enabled to contribute to the development of the service through regular team meetings. Minutes of these meetings showed that relevant issues were discussed and actions taken to follow up on areas that required improvement.

There was information telling people of the provider's ethos and objectives. However, people told us of some areas the service needed to improve in so that they provided consistently good quality care. These included: staffing; quantity and quality of activities; and provision of physiotherapy within the rehabilitation unit. About staffing, one person said, "They need more staff." Another person said, "Just one or two extra staff (on the unit) would make all the difference."

We discussed the provision of physiotherapy with the external professionals who provided this service and they told us that as much as possible, they aimed to ensure that people received the treatment they

required. However, there were instances when this was always facilitated as planned because staff had not supported people to get out bed in time or people had chosen to remain in bed. They also told us that they were working with the local hospital to try and manage people's expectations as they were wrongly being told on discharge that they would get intensive rehabilitation.

The team also raised areas where they thought the service could improve the way they worked with them for the benefit of people using the service. These included: working closer with staff to ensure a holistic approach to people's care; medicines management assessments should be done as soon as people were admitted to the service so that they were supported enough to manage these before discharge; discharge letters and discharge medicines arranged in a timely way. They however, found that a consistent member of staff attending the multidisciplinary team reviews had been positive as it improved communication. They also told us of initiatives they had started in the rehabilitation unit to improve people's activities and social opportunities. These included an exercise group on Wednesdays and a breakfast group on Thursdays. They told us that they would benefit from extra staff support to facilitate this. We discussed this with the area support manager who told us that they would continue to work closely with the rehabilitation team to ensure that people received the care, support and treatment they needed.

There were opportunities for people and their relatives to provide feedback about the service. The manager told us of plans to hold joint 'service user/relative' meetings soon. The provider had not yet sent a survey to people and their relatives and there were plans to do so soon. However, they completed one to one consultations with people and there was a feedback form for those admitted to the Rehabilitation Unit. There was also a feedback box where people could post comments and suggestions they might have. People and relatives also told us that they could speak with staff whenever they had concerns or comments about the service.

The provider had an effective system to assess and monitor the standards of care at the service. The manager frequently completed a variety of quality audits to ensure that people received consistently good care. Care planning and reviews, record keeping and medicines management were audited regularly. The suitability and cleanliness of the premises, infection control measures, health and safety, equipment and catering were also subject to regular checks. The provider's regional support manager had also completed audits, particularly in relation to how people's medicines were being managed. An action plan had been developed to show what staff needed to do to bring about lasting improvements. An inspection by the provider's assistant director of quality and compliance was in progress during our inspection. This demonstrated that the provider took a proactive approach to improve the welfare of people using the service.

There was evidence that the service worked closely with other agencies or organisations so that they could continually improve the care provided to people. The manager attended local provider forums to learn from others and share good practice. They also worked collaboratively with the local authority and the local Clinical Commissioning Group to continually improve standards of care. The service was part of the 'Hydration Project', a local initiative to ensure that people were supported to drink enough. Everyone we spoke with thought this was a positive way of monitoring how much people drank so that they do not get dehydrated, particularly in these warm months. The manager was also working with a local lead nurse who will provide end of life training to the staff.