Knighton Manor Limited

Holmwood Gardens Domiciliary Care Services

Inspection report

Holmwood Gardens
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Tel: 01162873072

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Holmwood Gardens Domiciliary Care Services provides care and support to people living in a supported living setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. In addition, Holmwood Gardens Domiciliary Care Service provides care and support to people living in 'houses of multi-occupation'. Houses of multiple occupation are properties where at least three people or more live in one household and share toilet, bathroom or kitchen facilities. CQC does not regulate premises used for supported living or multiple occupation; this inspection looked at people's personal care and support.

Not everyone residing at Holmwood Gardens received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.
At the time of the inspection 15 people were receiving a service. People's packages of care varied dependent upon their needs. Some people received continuous support over a 24-hour period, whilst others received support for a differing number of hours each day.

Holmwood Gardens Domiciliary Care Service had a registered manager. 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.

People's safety was promoted by staff who implemented the guidance as detailed within people's risk assessments and care plans. Assistive technology and equipment was used to promote people's safety and independence. People were supported by staff that had been recruited and had checks undertaken to ensure they were suitable for their role. People's medicine was managed safely and people received their medicine on time.

People's needs were assessed to ensure the service and staff could meet their needs. The level of support people received was dependent upon their needs, which included support to access health care appointments and dietary needs, which for some included support with grocery shopping, meal preparation and cooking. Staff received support from the management team, however the frequency of formal staff supervision was not consistent. We found, people were supported to have maximum choice and control of their lives and staff supported them in the least restrict way possible; the policies and systems in the service supported this practice. This included the use of assistive technology and working consistent with the Mental Capacity Act 2005.

People using the service and a majority of family members spoke of the positive relationships they had developed with staff. People's comments and that of their family members evidenced how these relationships had supported people, in gaining confidence to make decisions for themselves. People's dignity and privacy was promoted and people were aware of their right to confidentiality.

People's views, and in some instances, those of their family members had been sought to develop and continually review their care and support. Concerns and complaints had been investigated and documents supported this. People's care plans had considered the individual needs of each person and the role of staff in meeting these. People were supported by staff to access a range of activities within the community, which included for some going on holiday with the support of staff.

People's communication needs were considered when developing care plans, which included information as to how people communicated. This information was used to ensure people had the opportunity to make decisions and express themselves in a way that was understood by staff.

Systems were in place for people using the service and family members to comment upon and influence the service, which included the sending out of questionnaires seeking people's views. However, we found areas for improvement were required, to ensure the questions asked fully reflected the service provided and took into account the needs of people and why they used the service.

Staff's opportunity to develop and comment upon the service provided and learn from events and incidents were not maximised. This was recognised by the registered manager. Staff meetings were regularly held; however, the agenda of meetings did not provide an opportunity for staff to learn from incidents and events to make changes to their care practices. Staff received supervision, however the frequency of staff supervisions was inconsistent. The format and approach to staff supervision was restrictive and did not include an annual appraisal or personal development plan to reflect staff's aspirations, individual goals or training needs.

The registered person regularly visited the service, speaking with people who used the service, visiting family members and staff. Staff told us they found the registered person to be approachable. The registered person and registered manager regularly met, however their meetings with neither structured or recorded. This meant opportunities to review the quality of the service provided and to formalise ideas with a view to the development of the service within an agreed plan were not taken.

People using the service and a majority of family members expressed satisfaction with the day to day management of the service, and the registered managers approach to listening and acting upon their comments.

The registered manager had attained qualifications and attended courses on management and leadership, they told us their training had helped them in identifying areas for improvement and ideas they wished to introduce to further develop the service. Staff spoke positively about the support they received from the registered manager, which included their approachability and 'open door' policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from abuse as systems and processes were in place, which were understood and adhered too by all staff. A system of staff recruitment was in place to ensure people were supported by suitable staff.

People's safety was monitored, with risk assessments and care plans providing clear information for staff as to how people's safety was to be promoted. Assistive technology was used to promote people's safety and independence.

Protective equipment was used to reduce the potential risk of spreading infection.

People's needs with regards to their medicine were identified within their care plans, which included best interest decisions. People received their medicine at prescribed times by staff who had received training in medication and who had had their competency assessed.

Is the service effective?

Good

The service was effective.

People and family members were involved in the assessment of their needs. People's needs were met by staff that had the necessary skills and knowledge to provide the appropriate care and support required to maintain and promote their independence.

Staff spoke positively about the support they received from the registered manager. Staff were supervised; however, the frequency of staff supervisions was not consistent.

People's physical health was considered and staff liaised with health care professionals as and when required, in conjunction with family members.

People received support from staff to meet their dietary requirements, reflective of their individual needs and the level of

support required.

The principles of the Mental Capacity Act 2005 were understood and implemented, which included supporting people through best interest decisions to maintain their safety and well-being.

Is the service caring?

Good

The service was caring.

Positive and caring relationships between people using the service had developed, which had had a positive impact on people's well-being, which people using the service and family members confirmed.

People's privacy and dignity was maintained and people were aware of their rights, which included their right to confidentiality.

Is the service responsive?

Good

The service was responsive.

People and family members contributed to the development and review of care plans. Care plans were followed by staff and included information as to how people communicated to ensure their needs and wishes were understood by staff.

People and family members were confident to raise concerns. Records showed concerns and complaints were investigated and the outcome communicated to the complainant.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was in post who had undertaken training in management and leadership. The registered manager had identified areas for improvement, which were consistent with our findings.

There was an inclusive approach to the management of the service, through staff meetings and staff spoke positively about the approachability of the registered manager. However, the infrequent and restricted style of staff supervision meant specific areas of responsibility attributed to staff had gone unmonitored and shortfalls had not been identified.

The registered person regularly visited the service, speaking with

the registered manager, staff and people using the service. However, there was no record of their visit. Documented and formal meetings involving the registered person and registered manager did not take place to support the review and development of the service, with plans and timescales for implementation.

Systems were in place to monitor the quality of the service, which included the seeking of people's views and that of family members through questionnaires. However, the questions asked were not fully reflective of the service provided or individualised to reflect people's needs.

Holmwood Gardens Domiciliary Care Services

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 site visit started on 14 August 2018 and ended on 15 August 2018. We gave the service two working days' notice of the inspection because we wanted to provide an opportunity for people using the service and their representatives to meet us and share their views.

The inspection site visit was carried out by one inspector an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this time of care service.

We looked at the providers Statement of Purpose. This is a document providing information as to the aims and objectives of the service, the support and services it provides and to who.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We sought the views of commissioners who fund the care people receive.

We spoke with three people who used the service. We spoke with five family members in person or by telephone.

We spoke with the registered manager, deputy manager and four members of staff.

We looked at the care plans and records of three people. We looked three staff records, which included their recruitment, induction, on-going monitoring and training. We looked at the minutes of staff meetings and records related to the quality monitoring of the service.

Good

Is the service safe?

Our findings

People expressed how they felt about their safety in using the service and what being safe meant to them. One person told us, "I've got a button and the phone and I can call them (staff) at night, they come straight away. I'd keep pressing if it was urgent." A second person told us, "It's safe here, I'm loving it."

A family member told us how they had determined their relative was safe. They told us, "I feel [relative] is safe because of how [relative] is. I have got good relations with the staff. We are in constant contact every day, they tell me how [relative] is doing. If [relative] was unhappy, [relative] would show it." A second family member said, "Most definitely, I think [relative] is safe. [Relative] will now say 'my flat', so [relative] feels at home, at ease, and wants to be here. It was a milestone, [relative] didn't call other places home."

The registered manager responded appropriately when areas of concern were brought to their attention to ensure people's safety and welfare was promoted. Notifications were submitted to CQC about potential abuse and safeguarding referrals made to the local authority. The registered manager provided information required to the local authority to assist them with their investigations.

Staff had received safeguarding training and other training relating to safety, such as first aid. Staff understood what procedures should be taken if they suspected or witnessed abuse. This included contacting outside agencies such as the police, CQC and local authority safeguarding teams. Safeguarding was also discussed at team meetings to remind staff of their responsibilities.

People told us of the impact on them since they started using the service. One person told us, "I was in another place, a home with older people but it's better here. I'm more independent." We found examples of where people's general welfare had improved. For example, a person had gained confidence since moving to the service and was now more outspoken. People's care plans identified their skills and abilities so that their independence was maintained.

Personalised risk assessments, reflected all areas of people's day to day lives, which considered areas of potential abuse. The assessments identified potential risks and provided guidance for staff as to how these risks were to be minimised. People's risk assessments emphasised the promotion of people's safety whilst recognising the balance in promoting people's independence and choices.

A family member was confident that their relative was not at risk and talked to us about how potential risks had been minimised and the steps taken to reduce the risk. A family member said, "I don't think [relative] is at risk of anything. I've got a lot of confidence." A second family member, told us how the environment had been adapted to promote their relative's safety. They said, "Risk assessments are in place, we've had window restrictors put in."

The promotion of people's safety, incorporated the use of assistive technology and equipment. A family member spoke of how technology was used to promote their relative's safety. They told us, "Yes, things have improved a lot. [Relative] has a door sensor and floor sensor, anything to keep [relative] safe is all in place."

People's care plans detailed the use of assistive technology and equipment. For example, 'person to person pagers'. These were used by some people to request support outside of the times allocated to them for care. Two 'floating' staff were on duty each day, who provided support to people and staff as and when it was required, and these staff carried the pager so that they could respond in a timely manner. A further example of equipment being used was a mat, which detected when a person had an epileptic seizure, this sent an alert to staff so they could respond to the person to keep them safe and to ensure their needs were met.

People were supported by staff who had received training on how to support people whose behaviour could be challenging. Staff understood that people's behaviour was a form of communication. For example, people expressing a need, such as being hungry or thirsty, being in pain or wishing to take part in an activity. People's risk assessment and care plans for communication and support with behaviour provided clear guidance on how to reduce potential risk and the appropriate support to keep the people safe.

Staff supported people to manage their own environment by working with the landlord of the property. During our inspection maintenance issues were reported and rectified. Individual personal emergency evacuation plans (PEEPS) were in place, which provided guidance on the support people would require should they need to evacuate their flat or house in an emergency. A contingency plan was in place, which provided individualised alternative places of accommodation should the property not be habitable due to an unexpected event or adverse condition, such as a flood or electrical failure.

People spoke with us about the staffing hours allocated to them. "One person said, "I have set hours of support, but if I need staff I've got a pager for anything urgent." Staffing hours provided to meet people's needs were determined by the funding authority who undertook an assessment of their needs. People's care plans clearly identified the number of staffing hours allocated to each area of support. People in some instances received 24-hour support, whilst others received support for an allocated number of hours each day dependent upon their needs.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. Recruitment files we looked at contained evidence that the necessary employment checks had been completed before staff started to work at the service. These included application forms, identification documents and a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal record and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions.

Family members expressed confidence that their relatives were given the medicine they were prescribed. One family member said, "Any medication [relative] needs, they give correctly." A second family member told us that when their relative becomes upset there was the potential that they may hurt themselves, and that medication which had been prescribed to use when required was given to relieve their anxiety and stress and so reduce the potential for them to hurt themselves.

Staff received training on the safe administration and management of people's medicine and had their competence to administer medicine safely checked, which included the administration of medicine for some people who had their medicine administered via a PEG (percutaneous endoscopic gastrostomy). This means their medicine was passed via a tube directly into the stomach.

Where people did not have the capacity to consent to the use of medicine best interest decisions meetings had been held involving people who were involved in their care. The outcome of these meetings had identified staff would be responsible for the administration of people's medicine as being in the person's best interest.

Staff received training in infection control and food hygiene, to promote people's safety. Staff wore personal protective equipment, such as aprons and gloves when providing personal care and preparing food to reduce the risk of infection and cross contamination. Staff supported people to clean their flat and prepare meals, where the person's assessment had identified this as an area that the person required support.

Good

Is the service effective?

Our findings

People's needs were initially assessed by the funding authority, who shared their assessment with the registered manager. The registered manager upon receipt of the assessment reviewed the information to decide whether they could potentially meet the person's needs. The registered manager arranged to meet with the person and in some instances a family member, to carry out their own assessment. The registered manager told us they would meet with the person on several occasions to ensure a robust assessment of the person's needs was undertaken to ensure the service was appropriate for them. The assessment process was comprehensive, considering people's physical, communication and social care needs and any specific needs relating to protected characteristics as defined under the Equality Act, such as disability, race or religion.

People shared their views about their introduction to the service, which included an assessment of their needs. One person told us, "I visited (supported living accommodation) and my relatives came. It was good. I liked it. They (registered manager) asked me questions as far as I can remember, and my relatives helped. We went through paperwork, writing it down and saying what I wanted." A second person told us about their initial visit. "When I visited here I thought it was nice because I could go up and down to the car park, and I could get around." A third person said, "My family came to see the place."

Family members spoke to us of the assessment process for their relative and the support involved in moving into the accommodation. A family member told us, "We (parents) and the social worker had a meeting, and we had a look on the first floor. The registered manager came to see [relative] at home with me, and then [relative] went to see the flat." The family member went on to tell us how staff from the service got to know their relative and helped with the move into the supported living accommodation. They told us, "[Relatives] carer did a lot to get to know [relatives] routines at home and then went straight to the flat. It wasn't short visits, I don't think they would have worked. [Relative] settled well."

We found examples of where people's rights to technology and equipment were promoted by the registered manager. For example, the registered manager had liaised on behalf of a person using the service with the landlord to make adaptations to meet their specific needs and requirements. For example, to promote a person's independence a work surface and sink in their kitchen had been installed at a height accessible to the person who used a wheelchair.

We found some staff records did not provide evidence that they had received an induction when they commenced work. The registered manager said it was possible that some records may have been mislaid when files were moved during the office relocation. The registered manager said they would take steps to ensure staff files contained all the information required. Staff were supervised, however the frequency of staff supervision was not consistent. There was no evidence in the files we viewed that staff had had an annual appraisal. The registered manager acknowledged improvements were needed to the frequency of staff supervisions and that action would be taken. All staff spoken with were positive of the support they received from the management team, they said the registered manager had an open-door policy and they were always available to discuss any concerns and to provide advice.

Staff we spoke with could describe how they put into practice the training they attended. For example, staff told us how they managed PEG (percutaneous endoscopic gastrostomy) (which means their nutrition and medicine is passed via a tube directly into the stomach) sites and feed regimes for people. Records showed staff had received training in a range of topics to support the health, safety and well-being of people, which included attaining qualifications in health and social care. Staff had received training in specific areas related to people's individual needs, which included epilepsy awareness, enteral feeding (PEG), autism and learning disability awareness.

People spoke of the support they had with the shopping, preparation and cooking of meals, which for some people had been an area for increased independence. One person told us, "I kind of plan at the start of the day what I want, lunch I decide on the day." A second person told us, "They (staff) do my shopping, or I go with them. Food, they (staff) cook whatever I want." A third person said, "My staff do the meals, and they make tea and coffee or I do it myself."

A family member told us, "[Relative] now thinks about meals, and plans, thinking about what they want, [relative] feels more independent. [Relative] does as much as they can and their confidence is building, today they made tea for me." A second family member said, "Food and drink is all the stuff my relative likes, and they are healthier now. I do the shopping and the carers pick up bits and pieces. Staff do chicken and vegetables and things like that and my relative will help if they're in the mood."

People's dietary needs were documented within a care plan, which included any specific requirements the person had. People who required support, received help to undertake grocery shopping, and to prepare and cook meals. The level of support provided was dependent upon people's needs. A number of people using the service received their nutrition via an alternative method, known as a PEG, which means their nutrition is passed via a tube directly into the stomach. People's care plans for their PEG were comprehensive and records showed staff had received training specific to each person's needs. Staff spoke confidently to us about their role in supporting people with artificial feeding and were knowledgeable about the care of the equipment used.

People's records contained information and guidance produced by Speech and Language Therapists (SALT) where people required a soft diet to reduce the risk of choking. Care plans contained clear information and guidance as to the texture of people/s food, along with information where nutritional supplements were required. This ensured people's dietary needs were met to promote their health and well-being.

Initial assessments of people's needs included information of people's physical health, which included information on health-related conditions affecting their health. This enabled staff to provide continued support to people to meet their health needs, which meant continued liaison with health care professionals.

People told us, staff or their family member supported them to attend health appointments. One person told us, "My relative or staff go with them. I've never missed an appointment." Family members told us how their relatives health appointments were managed. One family member said, "I do the big ones for (specific health condition). The GP appointments staff do." A second family member said, "I take [relative] to hospital appointments, but staff come with us. I go to the doctors and dentists but they (staff) will do it if I ask, it's just I do it by choice."

People's level of support to attend care appointments was dependent upon their needs, in some instances people attended appointments independently, whilst others were supported by a family member or a member of staff. Where required, people had a 'health action plan', which held information about the

person's health needs, the professionals involved in their support, along with a record of appointments attended for the promotion of their health and well-being. Information about people's medicine, their likes and dislikes along with communication needs was also included.

Care plans were also used to support people's health and welfare needs, and detailed the role of staff in supporting people's independence to care for themselves. For example, people who were catheterised. People's care plans also provided guidance for staff on promoting people's health and their role in responding to changes.

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. Where 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. We checked whether the service was working within the principles of the MCA to ensure any restrictive practices had been referred to the local authority to ensure these were authorised by the Court of Protection.

Assessments to determine people's capacity to make informed decisions and choices were used to develop people's support plans and risk assessments. This ensured people's needs were met in a range of areas which included management of their finances, medicine, personal care, which included behaviour that could be challenging and accessing the wider community.

Good

Is the service caring?

Our findings

People shared their opinions of the staff and the relationships that had developed and how this had impacted on people's views on staff delivering personal care and support. One person told us, "They're (staff) kind, all of them and are respectful. When I use the bathroom I feel comfortable, staff don't rush me. When I go to the toilet there is a procedure I have to follow, staff know and they follow it." A second person said, "I think they (staff) do care, it's not just a job." A third person said, "They (staff) are kind, they chat with me. I love my staff, all of them." A person using the service told us they had a consistent group of staff, they told us. "I've no favourite staff. They're the same staff, they (registered manager) doesn't keep changing the staff."

A family member spoke of the relationship they had developed with staff. They told us, "They're (staff) caring and my relative has the same staff. [Relative's] got a team of five and gets on very well with all of them." A second family member told us that their relative had settled in well and how they had expressed this to them. "My relative loves it. They are always at the flat and get on with everybody. My relative doesn't want to come with me, as they want to stay with staff. When I visit after 10 minutes my relative gives me my bag and coat and says bye."

Family members shared positive comments of the relationships they had developed with staff and how these relationships had had a positive impact on the care and support their relative received. A family member said, "My [relative] has been here several months and we are now confident that they're settling in. The staff had to work out how to care for [relative]. They've (staff) always been able to ring me with a question." A second family member said, "My relative loves it. The first year was difficult, it was new and finding the right carers was a task, and my relative wanted to come home. But the whole package of care was intense. My relative doesn't want to return home now, they get 24 hours funded care."

People told us they were involved in the development and reviewing of their care plans. One person said, "I looked at my care plan and it's okay. My family members did it with me." The person showed us their care plan saying, "This is my care plan, it's all my plan." They then spoke about the specific parts of their care plan with us." A second person told us, "My care plan is alright, they (staff) do what I want." Family members confirmed when speaking with us their involvement in the development and reviewing of their relative's care plan. One family member said, "My relative has reviews a couple of times a year, but nothing really changes. All is going well and they (staff) speak to me as much as I need." A second family member said, "Reviews and care plans are done monthly, any changes in the care plans are updated accordingly."

Family members were confident that their relative's independence and dignity was promoted and that confidentiality was maintained. A family member told us, "Confidentiality and respect I have no issues with, I've never come across anything that has worried me."

Good

Is the service responsive?

Our findings

People's records contained information about their lives, prior to moving into supported living accommodation or their shared house. For example, information about family members, previous places of residence and information about their education, hobbies and interests. This information was used to develop care plans to support people's likes and dislikes.

People's assessments referred to people's communication needs, this information had been included in people's care plans where a need had been identified and provided comprehensive guidance and information for staff. For example, a person's care plan stated how staff were to interpret a person's body language, and provided information as to how objects could be used to communicate, such as car key, to reflect going out. Staff we spoke with had a good understanding of people's communication styles and shared with us how they communicated where people had no verbal communication.

People's care plans provided clear information and guidance for staff to enable them to respond to people's needs, which included their physical health, socialisation and activity of day to day living, such as shopping, cooking and cleaning. Care plans were regularly reviewed, a family member told us the service had responded to their request that their relative had a care plan developed, following a change to their needs.

During our site visit, we saw staff supporting people residing in the supported living complex, to access the wider community for a number of activities, which included shopping, social and recreational activities, which in some instances meant staff driving where people had their own car. Some people using the service had been supported by staff to go on holiday, whilst others had future holidays planned with the support of staff.

Organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. The service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS.

A key aspect of some people's care plans was the support they needed when their behaviour was challenging. A person's care plan stated the importance of a consistent approach by staff, and how good communication could prevent a person's behaviour from becoming challenging. For example, one person's care plan said staff were to introduce themselves to the person in a calm and confident manner, giving two clear choices, using pictures, or other objects to aid communication. Their care plan focused as to how staff were to be clear in their goodbye.

Key policies and procedures, including how to raise a complaint had been produced in an 'easy read' format. Using clear words and phrases, supported by pictorial images to support the written word. Documents, including support plans and health action plans were also produced in this format.

Information about raising a concern or complaint was available, which included the contact details for external organisations. The complaints we looked at had been investigated and the outcome shared with the complainant. Some complaints and concerns were not related to the service provided by Holmwood Gardens Domiciliary Care Services and related to the premises, these had been forwarded to the landlord to address by the registered manager.

We found family members experience of the management of concerns and complaints to be different. A family member stated concerns were not investigated robustly and the outcome was not shared. The complaints we looked at had been investigated and the outcome shared with the complainant. A second family member told us of their confidence in speaking with the registered manager about any concerns. They told us, "There's a good balance between personal care and other needs, and concerns I can discuss frankly without hesitation, and they have resolved things."

Requires Improvement

Is the service well-led?

Our findings

Holmwood Gardens Domiciliary Care Services had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager said they had completed their Level 5 Diploma in Leadership and management. In addition, they had attended a 'leadership pathway' programme over a six-month period, provided by the local authority. The registered manager told us training in management and leadership had been invaluable and that they had ideas following the training that they were looking to introduce. Proposed changes related to how the service was monitored and the quality of care provided. Other areas for development included reviewing the policy and procedure for seeking people's views, including a review of quality assurance surveys currently used to better reflect the individual needs of people and the service provided.

People who used the service and the majority of family members expressed satisfaction with the service they received or that received by their relatives. The majority of family members expressed confidence in the management of the service and the registered managers approachability and told us that they both listened and acted upon their comments.

We found the frequency and content of staff supervision did not provide sufficient opportunity and scope to share ideas, to reflect on incidents and learn and support the development of the service. The registered manager said they were committed to increasing the number, type and content of staff supervision to provide a greater level of support to staff. A range of audits were undertaken, which included audits on medicine administration, these had been delegated by the registered manager to identified members of staff. However, we found some audits had not been completed. This supports the need for the regular and targeted supervision of staff to ensure staff receive the guidance and support they need in the delivery of their role and responsibilities.

The registered manager, was supported by a deputy manager, senior support staff and support staff. Regularly meetings involving staff had taken place, providing an opportunity for the management team and staff to discuss and review their working practices. The registered manager said staff meetings could be improved and better use made of them, for example by sharing good practice and learning from incidents.

The registered provider regularly visited the service, speaking with staff and those using the service. Staff told us they would be confident to speak with the registered provider if they had any concerns. The registered manager informed us they regularly saw the provider, however there were no formalised meetings with minutes as to what had been discussed and the actions agreed. The registered manager acknowledged that the formalisation of these meetings, with a clear agenda to discuss and review all aspects of the service, would provide a valuable opportunity to identify and agree measurable goals and objectives for the development of the service, for the benefit of people and staff.

The registered manager had a good understanding of the requirements of their registration with the Care Quality Commission. All necessary notifications had been made to the CQC and we saw that the duty of candour had been adhered to following any incidents. Where necessary, the registered manager had undertaken investigations into incidents and complaints.

Surveys were sent to people and their family members, which sought their views about the service they received. The registered manager had collated information from these surveys, and produced a chart showing people's responses. People and family members in the main were satisfied with the service they received. The registered manager told us they would be revising the questions within the surveys to better reflect the service and to tailor surveys to reflect the wide range of needs people using the service had.

During our site visit, we heard the registered manager and deputy manager liaise with a range of health and social care professionals in relation to people's needs, providing up to date information as to the people's welfare. We also heard them liaising on people's behalf with other companies with regards to equipment. For example, manufacturers and suppliers of wheelchairs, to ensure people had the right equipment and that it was well-maintained.