Sun Healthcare Limited

Shaftsbury House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Shaftsbury House is registered to provide personal care and accommodation for 10 people over the age of 18 who have a learning disability; this includes two beds which are reserved for short term respite care. The service is situated close to local amenities and public transport routes. There are communal rooms available for people to use on the ground floor with access out to a large enclosed garden with seating. There is a small car park and further on-street car parking nearby.

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

We undertook this unannounced inspection on the 18 August 2016. At the time of the inspection there were 10 people using the service at Shaftsbury House. At the last inspection on 20 August 2013, the registered provider was compliant with all areas assessed.

People told us that they felt safe living at Shaftsbury House. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

Risk assessments were completed to guide staff in how to minimise risks and potential harm. Staff took steps to minimise risks to people's wellbeing without taking away people's rights to make decisions.

We found people who used the service received their medicines as prescribed. Staff managed medicines well and ensured they were obtained, stored, administered to people and disposed of appropriately.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

Positive interactions were observed between staff and the people they cared for. People's privacy and dignity was respected and staff supported people to be independent and to make their own choices. When people were assessed by staff as not having the capacity to make their own decisions, meetings were held with relevant others to discuss options and make decisions in the person's best interest.

Staff had access to induction, training, supervision and appraisal which supported them to feel skilled and confident when providing care to people.

People were encouraged to follow their interests and participate in activities.

A complaints policy was in place and we saw when complaints were received they were responded to in line with the policy.

A quality assurance system was in place that consisted of audits, checks and feedback from people who used the service. When shortfalls were identified action was taken to improve the service as required. The registered manager was a constant presence within the service and understood the requirement to report notifiable incidents to the Care Quality Commission.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The registered provider had systems in place to manage risks. Policies and procedures were in place to guide staff in how to safeguard people from abuse and staff received training about this topic.

People's medicines were stored securely and senior staff had been trained to administer and handle medicines safely.

Staff were recruited safely and there were sufficient numbers of staff available at all times to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported to make their own choices and decisions. When people lacked capacity, the registered provider acted within the principles of mental capacity legislation.

Staff had access to training, supervision, appraisal and support which enabled them to feel skilled and confident when supporting people who used the service.

People's health care needs were met and they had access to a range of community health care professionals.

People liked the meals provided and we saw the menus were created weekly based on people's individual choices. People's nutritional intake was monitored and recorded and dietetic advice sought when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that had a good understanding of their individual needs and preferences for how their care and support was delivered.

We observed the staff approach was patient and caring towards people who used the service. Staff had developed positive relationships with the people they supported and were seen to respect their privacy and dignity.

People who used the service were encouraged to be as independent as possible, with support from staff.

Is the service responsive?

Good

The service was responsive.

The provider had a complaints procedure in place and documentation on how to make a complaint was available in an easy read format. This helped to ensure documents were more accessible to people who used the service.

People who used the service had assessments of their needs and person centred care plans were produced which provided staff with information about how to care for people in ways they preferred.

People were supported to participate in a range of activities, hobbies and interests.

Is the service well-led?

Good

The service was well led.

Staff worked well as a team and told us they felt able to raise concerns in the knowledge they would be addressed.

There was a quality monitoring system which included audits to check systems were being used effectively. There were sufficient opportunities for people who used the service and their relatives to express their views about the care and quality of the service provided.

Staff told us they felt supported by the registered manager and described them as approachable.

Shaftsbury House

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.

The inspection took place on the 18 August 2016 and was unannounced, which meant the registered provider did not know we would be visiting the service. The inspection team consisted of one adult social care inspector.

We looked at notifications sent to us by the registered provider, which gave us information about how incidents and accidents were managed. Prior to the inspection we spoke to the local safeguarding team, the local authority contracts and commissioning team and the local Health watch. There were no concerns expressed by these agencies.

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

During the inspection we observed how staff interacted with people who used the service. We spoke with six people who used the service, the registered manager, a senior care worker and a care worker. Following the inspection we contacted two healthcare professionals to ask for their views on the service.

We looked at the care records for three people who used the service. We also looked at other important documentation relating to people who used the service such as five medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, the training records, the staff rota, minutes of meetings, quality

assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

People who used the service told us there were sufficient staff on duty to care for them and they were safe. They said they were treated well by staff and received their medicines on time. Comments included, "Yes there are enough staff," "I have a mobile phone that I can use when I am out," "They [staff] talk to you in a nice manner," "Yes I am happy and I'm safe" and, "I always get my medication on time. Sometimes I will get up later and have it then." A health professional told us, "My client goes out often and is accompanied by staff; she would not want to go out alone and feels safe with staff going with her."

People were protected from the risk of abuse. The staff we spoke with knew about the different types of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had never witnessed anything of concern in the service. One staff member told us, "I would know if people's behaviour had changed. If they appear down and are quiet and staying in their room. I would report it straight away to [Name of manager] or use whistleblowing or contact our head office."

Training records showed staff had received training in the safeguarding of vulnerable adults and staff told us updates of the training was also provided. One staff member told us, "I have had safeguarding training in March this year." Safeguarding and whistle blowing procedures were also seen to be in place. Whistle blowing is a way in which staff can report misconduct or concerns within their workplace. Staff were able to refer to these procedures if they needed more information.

We saw the registered provider had systems in place to ensure that risks were minimised. Care files contained risk assessments that were individual to each person's specific needs. This included assessed risk for safety in bed, moving and handling, nutrition and medication. We saw the risk assessments identified any equipment that was needed to safely deliver the person's care such as a pressure mattresses and hoists. We saw risk assessments were up to date and reviewed regularly.

Discussions with the registered manager and staff confirmed that restraint was not used within the service. One staff member told us, "We don't use restraint. We have done positive behavioural support training over two days which included theory and learning about the subject. The practical was about keeping yourself and other people safe. I have not had to use this yet." A person using the service told us, "I sometimes used to get angry and lash out at staff and now I will go to my room and listen to some music instead." This showed us that low level interventions and distraction techniques were effective in diffusing incidents or behaviours that were challenging to the service and others.

Details of actions taken to keep people safe and prevent further reoccurrences were recorded and whenever an accident or incident occurred, staff completed an accident or incident form. We saw these were collated and reviewed each month with outcomes and actions recorded. For example, 'District nurse contacted for advice and prescribed foam boots. Care plan and risk assessment updated.' This system ensured that steps were taken in response to events to reduce the risk of reoccurrences.

The registered provider's business continuity plan for emergency situations and major incidents such as

flooding, fire, failure of a major supplier or power failure identified the arrangements made to access other health or social care services or support in a time of crisis. The plan provided staff with information needed to ensure people were kept safe, warm and have their care, treatment and support needs met. This was last reviewed in March 2016. We also saw the 'emergency file' which contained a one page information sheet on each person which included their date of birth, GP, next of kin, mobility needs and medication.

We looked at maintenance records and safety checks which were carried out to reduce the risks in the environment. This included weekly checks on the fire alarm and checks on emergency lighting and fire extinguishers. We saw maintenance records for gas safety, electrical safety, lifting equipment, clinical waste and portable appliance testing. These checks helped to ensure that the building and equipment was maintained safely.

Personal Emergency Evacuation Plans (PEEPs) were in place documenting individual evacuation plans for people who may require support to leave the premises in the event of a fire. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

We looked at medication policies, procedures and systems and found that medication was ordered and stored appropriately in a trolley and cupboards in a dedicated medication room. The temperature of the room and fridge were taken each day to ensure medicines were stored at the correct temperature in line with manufacturer's recommendations. Those medicines which required more secure storage were held in a controlled drugs cupboard. The senior staff on duty had a clear understanding of how these would be stored, managed, administered and recorded within a CD book.

We observed staff administered medicines to people in a safe way. When administering medicines to people, they explained what they were doing, provided a drink and then signed the medication administration records (MARs) when they observed medicines had been taken. Some people were able to manage their own medication and we saw risk assessments were in place for this. One person told us, "They [staff] keep my stuff in the medication cupboard and the staff will bring it to me."

MARs were completed by staff who had responsibility for administration and included photographs of people which helped minimise potential administration errors. The MARs we checked were completed accurately without omission.

We saw protocols had been developed for 'as and when required' medication (PRN). For example, one person's PRN protocol for the use of paracetamol stated why the medication should be taken which was, 'for generalised pain, headache, toothache and stomach ache.' In addition to this we saw a clear description of behaviours and symptoms that might be exhibited to indicate that the person might require the medication which included, '[Name] may cry or point to areas that are hurting her.' This helped to ensure PRN medicines were used consistently and safely.

We found the level of cleanliness in the service was satisfactory. However, we found the area behind the tumble driers in the laundry required cleaning and part of the laundry wall required sealing/painting to make it impermeable when staff were cleaning the area. These were of low risk to the people using the service and had a low impact on their daily lives. We gave feedback to the registered manager and these minor issues were addressed during the inspection.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. There was a call system in place which alerted staff when people required assistance.

People knew how to use the call bell and it was placed within easy reach of people when they were in their bedrooms. One person told us, "Yes I have a call bell." Throughout our visit we saw that staff responded to people's requests for assistance in a prompt manner.

People told us they thought there was enough staff to support them. Comments included, "There is always staff around." Staff told us they thought there was enough staff during their shifts to safely meet people's needs. One staff member told us, "Yes there is enough staff and the senior manages the shift. If there are trips out planned we always get more staff in." A health professional told us, "The home retains staff well and they know my client very well." Staff rotas we looked at confirmed there were enough staff on duty to meet the needs of people living in the service.

We saw evidence in the two staff files we looked at to confirm staff were recruited following the registered providers recruitment policy. Prospective staff were interviewed before references were requested and a disclosure and barring service (DBS) check was completed. A DBS check is completed during the staff recruitment stage to determine whether an individual has a criminal conviction which may prevent them from working with specific groups of people. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

Good

Is the service effective?

Our findings

People felt that staff had the skills and experience needed to support them properly. One person told us, "It is a good environment and the support staff talk to you. We have got good support. They [staff] are trained in moving and handling and they cook our meal in an evening." Staff we spoke with told us that they received a full induction and training. One member of staff told us, "During my induction I shadowed other staff for a week and now new staff will shadow me. I was also introduced to the clients and observed practices. I am fully aware of my role and responsibilities and we always get a thank you if we help out."

We reviewed two staffs' induction records and saw they had completed the Skills for Care common induction standards through the local authority. These are a set of standards that people working in adult social care need to meet before they can safely work alone and are completed over a 12 week period. We saw the induction also included training courses in emergency first aid, safeguarding adults, fire safety, food safety, people moving people, equality and diversity, dignity and respect, last days of life, infection control and the mental capacity act and deprivation of liberty safeguards. There were also opportunities to attend a number of specialised courses available including diabetes awareness and epilepsy.

We spoke with staff and asked them about staff supervisions and annual appraisals. They told us they had regular supervision. One member of staff said, "I have supervisions every three months and an appraisal every year. During my supervision my manager will ask how I am. We will discuss the clients, training and if I have any issues. I have had the opportunity to complete two NVQ's." National Vocational Qualifications (NVQ) are now known as the Qualification Credit Framework (QCF). We saw evidence of these meetings in the two staff files we looked at.

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.

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. We looked at records and discussed deprivation of liberty safeguards (DoLS) with the registered manager, who told us that there were five DoLS in place.

We observed staff gaining people's consent before care and treatment was provided. People's capacity to provide consent to the care and treatment they required was recorded in their care plans. Best interest meetings had been held when assessments had been completed and it was apparent people lacked the capacity to make an informed decision themselves. Best interest meetings were attended by relevant health professionals and other people who had an interest in the person's care, like their relatives.

A health professional we spoke with told us, "Recently the home manager asked my advice following concerns about the clients' health and concerns about delays in the client getting any treatment she may have required. I advised an IMCA was appropriate and the care home promptly assisted in getting a referral from the GP." An IMCA is an Independent Mental Capacity Advocate. IMCA is a new type of statutory advocacy introduced by the Mental Capacity Act 2005 (the Act). The Act gives some people who lack capacity a right to receive support from an IMCA.

Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent. One staff member told us, "If the person can make their own decisions and choice then I would give them as much choice as I can. [Name] is non-verbal and we visually hold up clothes to help her choose, she knows her routine and I will ask her if she wants to get her shower things and if she wants to she will go and get them. If the person can't decide there would be a best interest meeting and peoples families would be involved."

People told us they had enough to eat and drink. One person said, "I make my own lunch and supper. We do a menu sheet and a shopping list every week and sometimes I go and do the shopping" and another told us, "We choose our meals." A staff member told us, "We complete a menu sheet each week with every person and then an overall menu for the week is put on the board with everyone's choices." A health professional told us, "My client is included in planning her meals."

We observed people completing their meal choices for the week during the inspection and people who were unable to verbally communicate were supported by staff to choose their meals from a picture book of various meals such as cottage pies, pizza, salads and desserts. People were also asked if they wished to go with staff to do the food shopping..

Staff told us people were supported to make a lunch of their own choice and during the inspection we observed people accessing the kitchen and making themselves and others drinks. At lunchtime several of the people using the service decided they wanted to have fish and chips for lunch and we saw staff supported them to go and do this.

People's needs in relation to nutrition and hydration were assessed by the service when required. This included details of their conditions and the level of support they required during mealtimes. We saw one person had a percutaneous endoscopic gastrostomy (PEG) fitted. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

Staff told us they were aware of people's specialist dietary requirements. One staff member said, "[Name] is PEG fed, [Name] is on a soft diet and for example has no crusts on their bread and the dietician is involved. [Name] used to have thick and easy but now has complan."

People's health care needs were met by a number of health professionals including GPs, emergency care practitioners, occupational therapists, speech and language therapists, dieticians and specialist nurses. One person who used the service told us, "I have been to the hospital and I see the doctor" and another person told us, "I am going to my doctor today and the support worker will help me with this."

Staff were knowledgeable about the people they supported. They were aware of their health and support needs, which enabled them to provide personalised care to each individual. One staff member told us, "People see their doctor, podiatrists, diabetes nurse, eye specialists and dentist and have regular medication reviews. Redness of the person's skin would indicate pressure damage and one person has a

pressure relieving mattress on their bed and we turn them frequently. If people show any sign of needing the toilet frequently or trouble breathing and are coughing it would be straight to their GP."

When concerns were highlighted, on-going monitoring of people's weight and food and fluid intake were undertaken, to ensure professionals had a clear understanding of people's needs. A health professional told us, "Weights are regularly taken for patients and food and fluid charts are completed when requested." We saw one person had lost weight and a referral had been made to their GP. This helped to ensure people continually received the most effective care to meet their needs.

Good

Is the service caring?

Our findings

All of the people we spoke with told us about how caring staff were. Comments included, "I like it here. [Names of two staff] look after me," "Yes they [staff] are kind and caring, they really care for people" and, "I am well looked after." A health professional told us, "I always find I am made welcome when I visit my client and am able to drop in to see her at any time. My client enjoys living there and the staff have a very good relationship with her, she is given choices and they promote her independence."

When we asked people if the staff encouraged them to be as independent as possible, they replied, "I help out whilst I'm here and do the hoovering" and, "I am involved in everything. I look after my own hygiene and I clean my own room." A health professional told us, "My client chooses her own clothes and where to go on outings."

In discussions, staff demonstrated a good understanding of how to promote privacy and dignity. One staff member told us, "This morning I helped [Name] get ready for the day. I knocked on his door and asked him if it was okay and told him what we would be doing. There were two of us to help him transfer and then the other staff member left his room whilst I helped with his personal hygiene. I made sure he was covered with a towel during personal care." One person using the service told us, "They [staff] always knock on the door before they come in my room."

We observed people were confident, relaxed and happy in the company of their peers and staff. Staff were seen to be caring and respectful of the people they supported and were able to observe people easily within the service, without intruding upon their personal space.

Each person was provided with a bedroom for single occupancy; this afforded them privacy. There were locks for bedroom, bathroom and toilet doors. A health professional told us, "My client is able to go to her room whenever she wants and I feel her privacy and dignity is respected."

One person who used the service told us they were the nominated dignity champion and we saw their photograph and information about dignity on a notice board in the service. The person told us they went to dignity forums and provided information from the forums to other people using the service during service user meetings. We were able to confirm this in the records we looked at.

The staff we spoke with were all long serving and knew the people who they supported. There was evidence of care staff knowing people's personal tastes but we saw they also checked with people for confirmation. Care plans included information about a person's lifestyle, including their hobbies and interests and the people who were important to them. This showed that people and their relatives had been involved in assessments and plans of care. Some people had signed their care plans to show they agreed to the contents. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager.

On the day of the inspection we observed that staff interactions with people were supportive, meaningful

and natural. Staff spoke with people while they were providing support in ways that were respectful, warm and friendly. There was positive interaction between staff and people which involved a great deal of laughter and light-heartedness. Staff used first names for people who used the service and were on friendly terms.

The registered manager and staff were aware of the need to maintain confidentiality and to keep personal information secure. Information regarding people who used the service was held securely in lockable cabinets and staff personnel files were held in the registered manager's office. Medication administration records were held with the medication in the locked treatment room and staff were able to hold shift handovers and make telephone calls to health professionals and relatives in the privacy of an office so they were not overheard. This helped to ensure peoples information was kept confidential.

Good

Is the service responsive?

Our findings

People who used the service told us there were activities for them to participate in if they chose and they felt able to raise concerns and complaints in the belief they would be addressed. Comments included, "I am going on holiday on Friday to the seaside," "[Name of staff] takes me to the Chinese restaurant and I go and play pool," "I go to a drop in on a Wednesday, they have a piano and I play it. I go to the [Name of public house] and play pool. Sometimes I stop in and sometimes I don't, I have my own bus pass," "I would raise any concerns I have with the manager," "[Name and Name] are my keyworkers and if I want I can talk in private with them," "I would speak to [Name of manager] or [Name of staff] if I was worried about anything" and, "[Name of staff] is good to speak to when I have a problem."

People told us staff were responsive to their needs and they had been involved in assessments and planning their care. Comments included, "I have my care plan. It includes what I like to do and notes about me. I have signed it myself and I am happy with it. Now and again I look at it and staff keep it up to date with new sheets and I sign it to agree," "Yes, I know where my care plan is," "I have signed my care plan and I was happy with it" and, "I signed my care plan. It's about my diabetes, my insulin and my hygiene." Two people asked a staff member for their care plans and brought them for us to look at with their permission.

A health professional told us, "I have found the staff to be responsive to the dietetic care plans which are put in place and at dietetic reviews staff are able to provide me with the information I need."

Prior to moving in to Shaftsbury House people's health and social care needs were assessed to ensure the service was suitable and able to meet their needs. Following the assessment process a care and support plan was developed with information from the assessment and the input of the person who had been assessed if this was possible. If appropriate, family members were also part of the assessment and admission process.

We looked at three people's care plans; each plan contained guidance for staff to ensure people received the support they required consistently and in line with their preferences. People's care plans had been written in a person centred way and re-enforced the need to involve people in decisions about their care and to promote their independence. For example, one person's care plan stated, 'I like to look smart.' We went to speak with the person during the inspection and we observed that the person was very smartly dressed.

Care plans included a document called 'All about me.' We saw this contained comprehensive information about the person which included a photograph, 'things you need to know about me', 'what I like to be called', 'my religion', 'important people in my life', 'things that make me who I am', 'a good day / bad day' and their likes and dislikes. This provided staff with important information about the person.

The care plans we saw covered all aspects of people's care and support needs including medicines, personal hygiene, eating and drinking, healthcare needs, mobility and behaviour. We saw that care plans were reviewed monthly or more frequently if the person's needs changed. Daily records were completed by

staff as a means of ensuring all the information about people who lived at Shaftsbury House was up to date.

People were supported to follow their hobbies and interests. One person who used the service told us, "I like colouring and drawing." We saw the person had their books and pencils with them during the inspection and the person showed us some of the pictures they had done. Others told us, "I like to listen to music, I like Queen and The Beatles and I went to watch Barnsley play football" and, "I like to go on my iPad and games are my favourite."

We saw there was a picture activity board at the service to show what activities were available and people had a weekly activity planner in their care files. We saw one person's planner included hydrotherapy, visits to the park, shopping and watching films. A staff member told us, "People go on holidays, shopping, into the local town, have their lunch out and visit Meadow hall and the zoo. [Name] has an iPad and a laptop and [Name] has a phone, laptop and PC. [Name] said they would like to go to the zoo so we planned a trip and took lots of pictures. Other people went to visit the set of Coronation Street."

People were supported to maintain contact with important people in their lives. Comments included, "Sometimes I go to my mums. The staff went with me to my granddad's funeral and I've now got photos of my nanna and granddad," "I speak to my mum and I go out with [Name of another person using the service] and my friend is always welcome and can come for tea" and, "I have sisters and nieces and nephews and my sister in law has been to see me."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. One staff member told us, "We have handovers and if someone had gone to hospital it would be in their notes. We discuss any changes in handovers and the senior always updates the registered manager."

People were offered choices and options. They had choice about when to get up and go to bed, when to have breakfast, what to eat, what to wear, and how they wished to spend their day. One person told us, "I get a shower when I want, sort out my own clothes and if I want to I will go into town." People's bedrooms reflected their personality, preference and taste. For example, some bedrooms contained people's own articles of furniture, pictures and their personal equipment such as TVs and DVDs.

A copy of the complaints policy was on display in the service in an easy read format. Easy read refers to the presentation of text in an accessible, easy to understand format. We saw that the service complaints procedure was also available in people's care files. Most people who were able to speak with us were aware of the complaints process. One person told us, "I would raise any concerns I had with the manager and I have done this in the past" and a staff member told us, "The majority of the time if a person has a grumble and it's minor I could help them sort it out. I have no doubt that complaints would be responded to."

Our checks of the registered provider's complaints log indicated that there had been two formal complaints made about the service in the last two years. We saw evidence that the registered manager had responded to these complaints and where necessary had sent the complainant a written response.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the service and people and staff we spoke with knew the registered manager's name. They told us the registered manager had a 'hands-on' approach to the running of the service.

Throughout the inspection we noted that people who used the service approached the registered manager and were clearly relaxed and content in their presence. The registered manager explained that a large part of their role was to be available for the people who used the service whenever they required support or reassurance.

When we asked people who used the service if they felt the service was well led we received comments including, "I can go to the manager with anything" and, "[Name of manager] is good and cares for us."

Staff we spoke with were complimentary about the registered manager. They said that they could talk to them about any issues and they were listened to, and that information discussed with the registered manager was kept confidential whenever possible. Staff had regular supervision meetings and annual appraisals with the registered manager and these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff. One staff member told us, "I feel comfortable going to the manager or my senior with anything. It is good working here. If I have any ideas I will raise them with the manager; I respect them and they respect me."

We asked for a variety of records and documents during our inspection. We found these were well maintained, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We observed that there was a good level of organisation within the service; staff we spoke with knew what they were doing and what was expected of them. We saw that there were clear lines of communication between the registered manager, the senior staff and the care staff. The registered manager knew what was going on within the service at an organisational level and about the specific needs of people using the service.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, keyworker meetings and one to one sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. The survey results we saw were consistently positive and there was evidence that comments or suggestions were implemented when possible. This helped to ensure people who used the service had an opportunity to develop the service and their views were heard.

We saw that the registered manager held regular 'service user' meetings and we were given the minutes of

the meetings held in March, April, July and August 2016. The items on the included safeguarding, health and safety, choices of activity for the following weeks, compliments/complaints and feedback from the dignity forum. We also saw that people using the service had made choices about new sofas for the service during these meetings. This meant people who used the service were able to express their views.

The registered manager conducted a number of audits and monitoring on different aspects of the service such as safeguarding, domestic, kitchen, medicines, care plans, rooms, first aid and emergency procedures and infection control. We saw monthly monitoring was completed in seven areas of the service which included effective care, consent to care, health care and meetings with individuals and staff. We saw evidence to confirm that action plans with appropriate timescales were developed to improve the service as required.

We asked the registered manager how they kept up to date with changes in legislation and guidance on best practice. They told us they received support with training from the local authority and attended forums. They also told us the service had two staff who were nominated 'champions' in safeguarding and end of life care. Through these roles staff had made links with community professionals who provided advice and support, and this was delivered to the staff team.

People were encouraged to maintain their links within the community through their social activities. This included family and friends taking them out and trips with the staff into the local area to social clubs, pubs and shops. Some people had on-line access to the internet so could keep up to date with news and views relating to their social interests.