Partnerships in Care 1 Limited

Cragston Court

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

The inspection took place on 15 and 17 March 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Cragston Court in May 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Cragston Court is a care home that provides nursing and personal care and support for up to 20 adults with long term mental health needs. At the time of our inspection there were 19 people living at the home.

The 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.

We found people were given support aimed at protecting them from risks without compromising their independence. Staff were trained to recognise and respond to abuse and any safeguarding issues that occurred had been notified to the relevant authorities.

The home provided a safe, clean and comfortable environment. Where necessary, people had individual aids and equipment for meeting their needs. Regular safety checks were undertaken and any accidents or incidents were properly reported and analysed.

There were sufficient numbers of staff to provide people with continuity of care and support the running of the home. The staff team were skilled and experienced in caring for people with mental health needs. They were provided with suitable training and supported in their roles to make sure people's needs were met effectively.

Arrangements were well co-ordinated for meeting people's health needs and accessing health care services. Prescribed medicines were stored safely and accurate records of medicine administration were kept. People had been consulted about their dietary requirements and preferences. There was a varied menu with choice of food and people could prepare their own meals, snacks and drinks.

People were fully involved in their recovery plans and, wherever possible, had given consent to their care and treatment. The management and staff had a good understanding of, and worked within the principles of mental health law to uphold people's rights and act in their best interests. Self-advocacy was encouraged and provision was made for independent advocates, when needed, to represent people's views.

Staff were caring and respectful in their approach and treated people as individuals. They promoted privacy and dignity and supported people to maintain control over their lives. People were given information about their care and the service to help them make decisions. Their opinions were routinely sought and acted on, enabling them to influence the service they received.

Care planning was tailored to each person's diverse needs and was kept under regular review. Staff worked flexibly and were responsive to changes in people's well-being. People were offered and engaged in a range of social activities and maintained links with the community. No complaints had been received and people told us they were happy with their support.

The home had an open culture where staff worked inclusively with people and their representatives. The quality of the service was monitored and there was an emphasis on obtaining people's feedback about their care experiences. The management provided good leadership to the staff team and were committed to continually improving the service. There was a clear vision for the future of the service with a number of planned developments intended to benefit the people living at the home.

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.

Risks were assessed and managed to promote people's personal safety.

Staff understood their responsibilities in safeguarding people against being harmed and abused.

There was enough staff to meet people's needs and provide consistent care.

Appropriate arrangements were made to safely support people with their medicines.

Is the service effective?

Good

The service was effective.

Staff were supported in carrying out their roles through training and regular supervision.

Wherever possible, people received care and treatment they had consented to. Formal processes were followed and people's rights under mental health law were understood and protected.

People were assisted in meeting their nutritional needs.

External professionals were accessed and people's health needs were regularly reviewed.

Is the service caring?

Good

The service was caring.

Staff had developed caring and supportive relationships with people living at the home.

People were able to make decisions about their care and were routinely consulted about the running of the service.

People were treated with respect and staff promoted dignified care and independence.

Is the service responsive?

Good

The service was responsive.

Care plans were focused on each person's individual needs and welfare.

People were supported to take part in activities to meet their social needs.

There was a clear complaints procedure that people could use if they were unhappy with the service.

Is the service well-led?

Good

The service was well led.

The service had stated aims and objectives and was well managed.

Staff worked well as a team and had good leadership and support.

Quality assurance systems were in place to keep checks on standards and develop the service.

Cragston Court

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 was 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 15 and 17 March 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a specialist mental health advisor.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted local authority commissioners who told us they had issued the service with an action plan following their last monitoring visit in January 2016 addressing staff training, policies, and risk management documentation.

During the inspection we talked with nine of the people living at the home and one person's relative and observed how staff interacted with and supported people. We spoke with the registered manager, the deputy manager, seven nursing, support and ancillary staff and a visiting professional. We looked at six people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People living at the home described being safely supported. Their comments included, "I'm secure here", and, "The staff treat us well." A relative told us, "I feel [name] is very well looked after and kept as safe as possible."

Information was displayed in the home to raise people's awareness of their rights to be protected from abuse and how to report any concerns. Staff were trained in safeguarding people against abuse and had access to policies and procedures on safeguarding and whistleblowing (exposing poor practice) for guidance. In the past year two safeguarding alerts had been raised by the service, neither of which had implicated the staff. The alerts had been notified to the relevant authorities and appropriately investigated. The provider had introduced a policy on the 'duty of candour'. This duty requires registered persons to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

The registered manager and staff had a good understanding of their responsibilities in keeping people safe from avoidable harm. We saw they struck a balance between promoting independence and recognising that people's lifestyles and actions could make them vulnerable. For example, we heard a recovery support worker discussing expectations with a person before going out into the local community, with the aim of preventing potentially adverse effects to themselves and others. Each of the staff we spoke with was able to explain how they would report any safety concerns and safeguarding issues.

There were robust systems for the handling of people's finances. The service had established where a minority of people had support with their finances through appointeeship, or a representative with power of attorney status, and took measures to support these arrangements. Most people had chosen to have cash held for safekeeping and made regular withdrawals for their personal expenditure. Cash was kept individually in numbered, sealed packets and all transactions were suitably recorded, backed by receipts for purchases, signed and counter witnessed. Weekly checks and a full annual financial audit were conducted to ensure that people's money was handled safely.

Records showed that a range of pre-employment checks were completed before staff were appointed. These included proof of identity; criminal records checks; references, including one from the last employer; interviews to establish suitability; and where applicable checks of qualified nurses' registration to practice. However, no application form or structured curriculum vitae (CV) format was provided to applicants. This meant sufficient background information might not always be obtained as there was reliance on the details given by applicants in their CV's or in letters. We brought this to the attention of the registered manager to follow up with the provider. Disclosure and Barring Service checks were renewed every three years and nurses' registrations were checked every six months to ensure they had not expired.

The home had a full team of nursing, support and ancillary staff and a bank of nurses. Staffing was determined according to the numbers and needs of people living at the home. The usual levels were one to two registered mental health nurses and two to three recovery support workers during the day and one

nurse and one recovery support worker at night. The registered manager and deputy manager were supernumerary to the roster and operated an on-call system outside of office hours for staff to get advice. They were also flexible in covering absence and working alongside staff when additional support was needed to safely meet people's needs.

Individual risk assessments were carried out and measures had been developed to reduce identified risks with the person's agreement, wherever possible. Factors such as medical conditions and mental health needs including historical self-injurious behaviour, aggression, self-neglect and compliance with treatment were addressed. There were also strategies for the everyday support that some people needed, such as staying safe whilst showering and making hot drinks. A person we talked with understood the risks associated with their care had been assessed and told us, "I'm keen to make progress."

We observed that the home was clean, comfortable and well maintained. A qualified maintenance person was employed who undertook regular safety checks and any necessary repairs and decoration. Safety standards were also audited to check compliance with areas including infection control, food hygiene and risk management within the environment. Any accidents or untoward incidents which occurred were reported, analysed and reviewed at staff and regional managers meetings to see if lessons could be learned. Arrangements for emergency circumstances had been made which included an identified place of safety and continuity plans for people's care if the home ever needed to be evacuated.

Prescribed medicines were kept under regular review by people's consultant psychiatrists and GP's and, wherever possible, self-management of medicines was encouraged. The registered manager reported that GP's were responsive in adapting medicines to suit people's needs and would prescribe medicines in liquid form or more concentrated doses. Some emergency 'standby' prescriptions were provided to enable medicines such as antibiotics to be readily available. We were told the home received a good service from the supplying pharmacy and that items were delivered quickly, including those prescribed outside of the usual medicines cycle.

The nursing staff took responsibility for ordering and administering medicines. They were trained every three years in the safe handling of medicines and had their competency assessed annually. Medicines were held securely in locked, well organised and hygienic facilities and most were dispensed in blister packs. No medicines were given covertly (disguised in food or drinks without the person's knowledge). We saw that records of administration were correctly completed and protocols for medicines given on an 'as required' basis were followed. Various checks and audits were undertaken by staff and the supplying pharmacy to assure people their medicines were being safely managed.

Good

Is the service effective?

Our findings

People living at the home praised the support they received. One person told us, "I love living here and wouldn't want to move out." Another person said the management made "wise choices" when employing new staff and a relative described the staff team as "experienced and professional".

We saw that new staff had completed an induction training programme to prepare them for their roles when they began working at the home. The registered manager told us a new induction process had been introduced that encompassed the Care Certificate, a standardised approach to training for new staff working in health and social care. New staff spent time shadowing experienced colleagues and arrangements were made for nurses to work in addition to the usual staffing levels for their first two weeks. This gave them time to begin to become familiar with people's needs and the home's routines.

The staff team were provided with a range of face-to-face and e-learning training. All staff had undertaken mandatory training in safe working practices of moving and handling, fire safety, health and safety, first aid and infection control. Each day the names of the designated first aider and fire warden were highlighted on the notice board in the reception area. Other courses relevant to the needs of the people living at the home had been completed. These included person centred care, positive behaviour support, equality and diversity, safeguarding and mental capacity law. 12 of the recovery support workers had achieved nationally recognised care qualifications.

There was a delegated system for providing staff with individual supervision that was overseen by the registered manager. All grades of staff were supervised every four to six weeks to support their personal development. The staff we talked with were happy with the training and support they received. The deputy manager told us there was a good mix of skills and expertise in the team and that staff worked well together, taking consistent approaches to people's support.

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

We found that staff had a good knowledge of, and worked within the principles of the MCA and the Mental Health Act 1983 (MHA). Many of the people living at the home were receiving aftercare services following discharge from hospitals where they had been detained under the MHA. Four people had DoLS authorisations granted and one person was supported in line with a treatment order that set out the conditions they had to meet in order to live in the community. Appropriate supporting documentation was in place and people were given information about their rights.

People living at the home were able to direct their care and those who were able had signed to confirm they had given consent to their care plans. Where necessary, formal processes were followed to carry out mental capacity assessments and make decisions in a person's best interests. It was evident that such decisions were kept under review and we saw, for example, that a person's capacity had been reassessed as their mental health improved. In another example, there had been negotiations with hospital solicitors to enable a person to have essential surgery that was judged to be in their best interests. The person was supported throughout the procedure by the deputy manager, with whom they had a trusting relationship, and had resulted in their improvements to their physical and mental well-being.

The service did not advocate the use of restraint or excessive control. All staff were trained in de-escalation and 'break away' techniques to prevent the person and themselves from being harmed. Contingency care plans addressed the psychological and practical support that staff would provide in the event of a person's mental health deteriorating and in crisis situations.

Staff worked in a co-ordinated way with other professionals to meet people's health needs. There was close liaison with consultant psychiatrists who carried out multi-disciplinary team (MDT) meetings with individuals every four to eight weeks. Meetings were being held during our visit and we observed that people living at the home were routinely involved. A relative told us they had attended their family member's review meeting with their agreement. They said the person decided the frequency of their meetings and fully contributed to the decisions made.

The visiting consultant confirmed people and their representatives were encouraged to participate in their MDT meetings. If they did not want to attend, their wishes were respected and they had the option of seeing the consultant in private. The nursing staff also updated individuals with any recommendations made, including changes to medicines and therapeutic activities which would effectively support people in maintaining their mental health.

Each person had access to health care professionals and a physical health care plan from their GP that was reviewed at least annually. The nursing staff monitored some elements of physical health, specific to the person's needs, including baseline health checks and blood glucose levels for people with diabetes. Two people had individual aids and equipment to support independent mobility in the home and in the community. A relative told us they felt their family member's health needs were well attended to.

The people we talked with were complimentary about the meals provided at the home. A typical comment was, "The meals are very nice." We saw nutritional needs were assessed and we were told no-one was currently identified as being at risk of malnutrition. People's weights were monitored monthly or more often if staff noted any changes in appetite.

A four week menu was in place that offered a balanced diet with choices of food at each meal. The chef had gathered information from each person about their dietary requirements and preferences and attended resident meetings to get everyone's views about the food. A healthy diet was promoted and the chef had good understanding of catering for special diets, fortifying food and supporting people with weight management. They also ran weekly cookery groups and individual cooking sessions with people to help support their independent skills.

Good

Is the service caring?

Our findings

People living at the home told us they were treated kindly by the staff and described having good relationships with them. One person commented, "The staff are lovely here." A relative told us, "The staff are all very kind and caring" and said they were kept well informed about their family member's welfare.

We observed that staff were caring and respectful in their manner towards people. They spent time engaging and supporting people on an individual basis and encouraged them to be involved in daily living and social activities. Staff told us they adhered to the NHS 'six C's' of creating a culture of care, compassion, competence, communication, courage and commitment. Each of the staff we talked with had sound knowledge and understanding of the needs and vulnerabilities of the people they cared for. They were able to give accounts of people's histories, their current states of well-being and describe the best approaches to take with individuals to gain their co-operation.

People at times sought reassurance from the staff and we saw that they took time to listen to what people had to say, acknowledged their feelings and made gentle suggestions, where appropriate. When talking about people, the staff spoke respectfully and highlighted the positive aspects of their journey of recovery. For instance, where a person's mental health had been unstable when they first came to the home, we were told they now exercised more control over different areas of their life. The person had insight into when their mental health was declining and we saw they asked one of the nurses for an 'as required' medicine that helped alleviate this at an early stage.

During our visit we observed many sensitive interactions, including staff being very patient with people and taking action to preserve a person's dignity. In another instance, we heard a telephone conversation between a person who was currently in hospital and the registered manager. The person wanted to come back home, though this was not possible at the time. The registered manager was caring and spoke calmly, asked about their well-being and reassured them they could return when they were feeling better. They reminded the person how well they responded to one-to-one and suggested perhaps they might also want to talk things over with their named nurse at the hospital. The registered manager then spoke to the doctor on the ward to get an update and later in the day spent time comforting the person's relative when they called into the home.

We noted that the practice of people being given their money in a public area did not uphold their rights to privacy and confidentiality. This was raised with the registered manager who gave us assurance the practice would be changed immediately.

Staff told us that people were only supported with personal care where this was needed. They encouraged people to take pride in their appearance to help promote self-esteem, though some were often resistant to intervention. For example, the registered manager was concerned that a person routinely looked unkempt. They explained the person took regular showers though refused to wear new clothes or accept support with their personal grooming. However, staff took the opportunity on those occasions when the person would allow them to provide support.

It was evident that the service supported people to maintain control as far as possible over their lives, supporting them to make their own decisions and retain independence. We saw that self-advocacy was promoted and where necessary some people received support from Independent Mental Capacity Advocates. A variety of methods were used to assist people to express their views and make decisions about their support. These included people being involved as much as they wanted to be in their assessments, care planning and reviews of care. Individual and collective views about the running of the home were sought at monthly resident meetings and surveys were carried out to check people's satisfaction with the service.

An informative range of information was displayed in the home for people to refer to. This included details of the staff on duty, planned activities, the home's newsletter, minutes from the last resident meeting and local news and events. There was also information and leaflets on topics such as advocacy, mental capacity, the latest Care Quality Commission inspection report and how to make suggestions, ideas and complaints.

The care environment supported people's privacy and independence. A pay telephone was available and some people had landline or mobile telephones. People told us they held keys to their bedrooms and either took responsibility for, or were given support from staff with everyday household chores and laundry. Those who were able could make their own drinks and many people liked to get involved in cooking. Where people had physical disabilities, we saw that staff helped them with opening doors to allow wheelchair access and accompanied individuals to go out into local community.

Small, quiet sitting areas were provided in the home as well as the larger communal lounges and dining area. Some bedrooms had verandas and the garden was accessible, had seating and was well used in warmer weather. There was an outdoor designated smoking area that did not afford people much shelter. The manager confirmed they were looking towards investing in a more suitable smoking shelter and showed us this had been discussed with people at the latest resident meeting.

Good

Is the service responsive?

Our findings

People living at the home were happy with the care and support provided and no-one expressed any concerns. A relative told us they had no complaints and would not hesitate to raise any issues on behalf of their family member if this became necessary.

The registered manager told us that the staff team were well attuned to people's needs. They said staff were highly aware of the individualised approaches to deal with people's behaviours, which could be unpredictable due their mental health problems. Our observations confirmed this. We saw for instance that staff acted quickly to defuse a potential altercation between two people and ensured they were given a safe space to work through their difficulties with support from staff.

The service had clear criteria for admissions and used a range of detailed assessment formats to ensure they could meet the person's needs. These included risk indicators and identifying the person's support networks. The assessment process included a phased introduction to the home to enable the person to meet staff and other people before a final decision was made. A respite service was also currently being offered.

Once the person's needs and strengths had been identified, care plans were developed with the person to meet their needs. The model used for this was one of incremental recovery, where the person was supported to take steps in their daily lives that would enhance their social skills, develop their feelings of self-worth and improve their quality of life. Steps might be small at first (for example, just coming out of their bedrooms more often) but with positive reinforcement from staff people were able to set progressively more challenging targets as they grew in confidence. For instance, a person who was initially unable to go further than the local shops had, with encouragement and support, now been out four times into the wider community.

We saw that care plans were tailored to the individual's abilities and wishes, including agreed actions and desired outcomes. People were given some choice as to their key worker to increase their involvement in the planning process. Care plans were formally agreed with the person and were reviewed every month, with the person where possible. Plans were fine tuned in response to the progress made over the previous month.

Each person had a 'relapse' plan in place, with contingency arrangements, so that the effects of any relapse in mental health would be minimised. We were told about the way the service had responded to meet the needs of a person who had suffered an acute mental health episode. The staff had acted with an immediate full team approach that ensured the person received the appropriate specialist input to meet their needs, and that they and the other people living at the home were given the necessary support. The registered manager commented on how caring and accommodating the other people had been towards the person during this time.

The staff team demonstrated a clear commitment to person-centred care. One of many examples was that of a person who during our visit had to attend hospital for tests. The person was known to be stressed by the

prospect of spending long periods of time in unfamiliar surroundings. Staff had therefore arranged for them to have the initial tests and then return to the home for a period, before returning for the remainder of the process. The person had also been given a small dose of anxiety-reducing medicine. This person told us how much the staff interventions on their behalf had been appreciated and said, "It went well." Another person told us they had informed staff they wished to go on holiday to see family members. The staff had followed up their request and the person said they were going on holiday in a week's time. We talked with a staff member about this plan who told us that it was deemed beneficial to the person's health needs and they had reviewed and updated risk assessments and care plans in relation to the holiday.

The home was organised to provide the structure necessary to support people with their recovery. Staff were allocated to different duties each day, including meal times, support with personal care, supporting people with their bedrooms, activities, and any escorts for appointments. We observed that staff worked flexibly to respond to people's needs. The communication between staff was good, with detailed records kept of daily events and personal progress which were shared at the shift handovers. At regular points throughout the day we observed the recovery support workers feeding back to the nurses about issues relating to individuals.

A four week activities programme was in place. Staff told us they canvassed people's views on suitable activities, and used their knowledge of the interests of people who lived at the home. The objectives of the programme were to provide structure and framework for activities, engage with people and support participation in meaningful on-site social and leisure pursuits. The aim was to reduce the risks of people being socially isolated. The activities offered included a cookery group, karaoke, bingo, quiz, gentle exercise, a singing group and film afternoons. There was also pampering sessions for the ladies, occasional entertainers and coffee mornings to which people from the local community were invited. The programme was flexible enough to allow for other activities to be decided upon by people on the day. A resource file was kept that gave staff guidance, describing the activities, possible methods of delivery and the materials and resources required.

The nurse who took responsibility for the activity programme told us how important it was to sustain the impetus and enthusiasm for activities, and to review and evaluate the activities provided. We saw that activities had been evaluated, looking at the popularity of each activity and deciding what to continue or discontinue. These evaluations had also looked at how the lounge area could be enhanced, incorporating people's suggestions including air hockey and table tennis games.

We saw staff were involved in and committed to the activities programme. A karaoke session was taking place in the lounge and we noted good interactions between people and staff. Staff demonstrated good rapport and encouraged people to join in, including getting the registered manager to join in the singing. A 'clothes party' also took place, giving people the opportunity to buy new clothing which we saw many enjoyed.

People were encouraged to follow their own hobbies and interests and a minority of people went out unaccompanied to pursue their leisure interests. People regularly used local facilities including shops, café, post office, supermarkets, a social club and one person went to church. The registered manager told us they were looking into getting their own mini-bus transport for the home. Where appropriate, staff supported people to go out socially and helped with shopping and there were regular outings for pub lunches and trips to the coast. A person we talked with told us they really enjoyed these outings.

The complaints process was displayed in the home and people were reminded of its' existence. People's understanding of the process was also checked in surveys. Staff were provided with complaints training and

the service had a dedicated complaints officer who was responsible for ensuring all complaints were taken seriously and responded to professionally and promptly. We noted that no complaints had been made in the last year and in this time 14 compliments about the service had been received.

Good

Is the service well-led?

Our findings

The home had an established registered manager who demonstrated good understanding of their registration requirements and management responsibilities. They were well experienced in nursing and personal care services and held qualifications in management and leadership. The registered manager was not a qualified nurse and told us they were ably supported in their role by the deputy manager who was an experienced registered mental health nurse. We observed this was a dynamic partnership and that both parties' skills in management and clinical issues complimented one another and provided robust leadership for the staff.

The registered manager kept up to date with best practice and had, for instance, attended a workshop on the regulations and fundamental standards of quality and safety set by the Care Quality Commission. They told us they attended regional board meetings, cascaded information to staff and played an active role within the company. For example, as many of the company's services were independent health care hospitals, the registered manager was leading on adapting the provider's policies, procedures and quality assurance methods to correspond to care home settings. They were also working with other managers to review the staffing models in the provider's care homes.

People told us they felt the home was well run. One person said, "[Name] manages the home really well" and we heard another person say to the registered manager, "You do me proud." A relative told us, "[Name] is a good manager." We observed the registered manager and deputy manager directed and worked alongside staff and were involved in providing psychological support to the people living at the home. In their absence, we saw the nurses on duty structured the day for the staff team and were well organised.

The staff we talked with told us they felt well supported and one staff member commented, "I feel the company is interested, invests and makes staff feel valued." Staff meetings were held monthly to discuss practice and employment issues and the findings of a recent survey of staff's views were awaited. We were told employee benefits included a health support programme, the availability of lease cars and a competition incentive for staff to enter in relation to training undertaken.

The staff and management were clear that the focus of the service was to promote recovery at the individual's pace. The registered manager told us the ethos of the home was 'Everyone can achieve, everyone's journey is different, and everyone is unique'. We saw the home's philosophy statement was on display, setting out the mission, beliefs, behaviours, experience and outcomes that underpinned the care provided and how these were being achieved. The service ensured that people's care was appropriately co-ordinated through partnership working with other health and social care professionals.

We found there was a culture of openness and people were able to influence the service they received. One person produced a newsletter for the home and drew up the agendas and chaired the resident meetings. At the latest meeting a variety of issues had been debated concerning the environment, housekeeping, health and safety, activities, outings, holidays, and changes to keyworkers. People's opinions had clearly been sought during the meeting and were acted upon. For example, where people had enjoyed a meal out at a

particular venue and wanted to return, this had been planned for the following week. We noted people gave thanks and praised the staff team for their work and the changes that had been implemented in the home.

Positive feedback was also seen in surveys which people had completed. The findings showed people were happy with the service, the staff and the support they received; their goals/expectations were met; they were treated fairly and with respect; and most people had said they would recommend the service to others.

A regional executive director had regular contact with the registered manager and visited the home on a monthly basis. They received weekly reports appraising them of the running and performance of the service and any significant events. A range of checks and audits were carried out to monitor the quality of the service that people received. A compliance manager from the company conducted quality visits covering aspects of the service such as the environment, care records, food, and any complaints and safeguarding alerts. During their visits they spoke with people, looked at the findings of surveys and observed staff interaction to assess people's care experiences. These visits highlighted any actions required to improve the service and set three priorities for developing the outcomes and involvement of people living at the home.

The registered manager described the developments that were planned for the service. A three year business plan was in place for investment in the environment. All bedrooms were being redecorated and air conditioning was being installed in the building during our inspection. New commissioning arrangements had been secured resulting in improved funding for people's care services. This gave greater scope for flexibility in the staffing and it was proposed that senior recovery support workers roles and a senior nurse role would be created to further improve the management structure. Planning permission was being sought to develop a new building within the site for independent living accommodation, aimed at being part of a step down rehabilitation plan to support people back into their own homes. The registered manager reported this was being thoroughly researched before going ahead.