

Look Ahead Care and Support Limited

Nimrod House Registered Care

Inspection report

11 Vanguard Close
Butcher's Road
London
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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 21 February 2018 and was an unannounced inspection. This was the first inspection of Nimrod House Registered care since its registration on 11 April 2016.

Nimrod House Registered Care is registered to provide accommodation and personal care for up to three adults with learning disabilities and autistic spectrum disorder. Nimrod House Registered Care is a building containing five one bedroom flats. The provider has two registered locations at the address. Up to three of the flats can be used to provide registered care, and the remaining are supported living flats for adults with learning disabilities. This inspection related only to the registered care aspects of the service. At the time of our inspection two people were living at the service. People using the service lived in one bedroom flats with a living room, kitchen, bedroom and a bathroom. They shared garden space with other people using the service.

Nimrod House Registered Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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.

The provider had systems to ensure people were safeguarded against avoidable harm. A person and a relative told us staff were trustworthy and they felt safe with them. Staff knew how to identify and report abuse and poor care. Risks to people were identified, assessed and mitigated. People's risk assessments were regularly reviewed and provided guidance to staff on how to support people safely. Staff were appropriately recruited and vetted before they started working with people. There were enough staff in place to meet people's individual needs. People's medicines needs were met safely. The provider met infection control requirements and there was no malodour in the flats we visited. The registered manager learnt lessons from complaints, safeguarding and accidents and incidents, and shared the learning with the staff team via staff meetings.

Staff received comprehensive induction, regular training and supervision to provide effective care. People's nutrition and hydration needs were met. Staff assisted people in accessing ongoing healthcare support. People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible. The policies and systems in the service supported this practice. Staff gave people choices and understood the importance of seeking permission before providing care.

Staff were trained in equality and diversity, and people told us staff treated them with dignity and respect. People were supported with their cultural and religious needs. People's care plans gave information on their likes, dislikes and cultural and religious preferences.

The provider maintained clear complaints processes and encouraged people and their relatives to raise concerns. The provider's end of life policy informed staff on how to support people with their end of life care wishes.

People, their relatives and staff told us they found the registered manager approachable. Staff told us they felt well supported by the registered manager. The provider involved people, their relatives, healthcare professionals and staff in improving the service. The provider conducted regular monitoring checks and audits to ensure the safety and quality of the service.

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.

A person and a relative told us they felt safe with staff. The provider followed appropriate procedures to safeguard people against harm and abuse. Risks to people were identified and mitigated to ensure people were safe in their flats and in the community.

People received medicines on time. Staff were appropriately checked before they started working with people. The provider followed safe infection control practices.

Is the service effective?

Good ●

The service was effective.

People's needs were appropriately assessed. They told us staff looked after them well. Staff received regular training and supervision to meet people's individual needs.

Staff asked people's consent before providing care and encouraged them to make decisions. People's nutrition and hydration needs were met and they were assisted to receive ongoing healthcare support.

People liked their flats and the provider used assistive technology to deliver effective care.

Is the service caring?

Good ●


The service was caring.

People were treated with dignity and respect. Staff were trained in equality and diversity. People's cultural and religious needs were recorded in their care plans and staff supported them in meeting those needs.

Staff supported people to learn daily living skills and remain as independent as they could.

Is the service responsive?

Good ●

<p>The service was responsive.</p> <p>People received personalised care support from staff who knew people's likes and dislikes. People's care and health action plans were person-centred and regularly reviewed. The provider had developed a 'hospital passport' which provided important information about people's healthcare needs.</p> <p>The provider encouraged people and their relatives to raise concerns and complaints, and maintained accurate records of complaints. There was an end of life policy in place that informed staff on how to support people with their end of life care choices.</p>	
<p>Is the service well-led?</p> <p>The service was well-led.</p> <p>People, relatives and staff found the registered manager approachable. The provider carried out regular checks and audits to ensure people received a quality service.</p> <p>The provider consulted with people, relatives, staff and healthcare professionals to improve the service.</p>	<p>Good </p>

Nimrod House Registered Care

Detailed findings

Background to this inspection

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

This inspection took place on 21 February 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to our inspection, we reviewed information we held about the service, including notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We contacted the local authority about their views of the quality of care delivered by the service.

During our visit to the office we spoke with one person using the service, one relative, the registered manager, a team leader and one of the care staff. We looked at two care plans and six staff personnel files including recruitment, training and supervision records, and staff rotas. We also reviewed the service's accidents and incidents, safeguarding and complaints records, care delivery records and medicines administration records for people using the service.

Following our inspection visit, we reviewed documents provided to us after the inspection. These included policies and procedures, staff and residents meeting minutes, training matrix, care plans and risk management plans, activity plans, the manager's quality audit and incidents analysis.

Is the service safe?

Our findings

A person and a relative told us the service was safe. A person said, "Yes, I am safe." One relative commented, "Yes I trust staff and he is safe here."

Staff received annual refresher training in safeguarding. The provider's safeguarding policy gave information on abuse, how to identify abuse, and internal and external reporting procedures. Staff knew the signs and types of abuse and told us their role was to ensure people were safeguarded against harm and abuse. A staff member said, "To make sure [people using the service] safety is met, if [people using the service] are in any danger, act immediately to remove the risk, report any concerns to the line manager." Staff were aware of external authorities' role in investigating concerns of abuse and told us they felt comfortable in reporting to the higher authorities if the registered manager did not act appropriately. One staff member commented, "I would take note what staff said. Would speak to the manager for investigation. If nothing done speak to [head of Learning Disability for provider]. If she did nothing about it would go to CQC." We reviewed safeguarding logs, they were clear and accurate. The provider followed appropriate systems and processes to safeguard people against abuse and avoidable harm.

We found the provider took appropriate action to ensure people were safe in their living environment. For example, for one person who was at risk of head injury due to having a history of banging their head against walls, their flat walls were fully padded with soft mats. This ensured the person was safe and did not sustain any head injuries. This person's relative told us, "[Person using the service] tends to bang his head against the wall, they [the management] have done well padding the walls, has made a difference. [Person using the service] head wound had never healed before, but has now healed as [person using the service] has not sustained any head injury since moving here."

People's risk assessments were individualised and were for areas such as personal care, environment, self-neglect, medicines, activities, behaviour and specific health conditions such as epilepsy. The risk assessments identified risk areas, triggers, signs and measures to reduce risks. For example, for one person at risk of choking their risk assessment informed staff to ensure the person was sitting "upright" and to encourage the person "not to eat or drink while lying down, to ensure food is cut into small pieces, to observe, monitor and supervise [person using the service] at all times." The risk assessment also detailed signs of choking and actions staff were required to take if the person was choking. People's risk assessments were reviewed every three months and as and when people's needs changed. The provider had recently reviewed their risk management plan template to ensure they provided sufficient information to staff. The team leader told us, "Either me or [registered manager] do risk assessments. Quality team will have a look [at risk assessments] and send back to us. Gets reviewed every three months or if there is an incident. I oversee the keyworker doing it [risk assessments]. Every time do incident logs update risk assessments." This demonstrated that the provider identified, assessed, mitigated and reviewed risks to people, and informed staff on how to provide safe care.

The provider had a central recruitment team who managed the recruitment process for new staff. Following an initial application form submission candidates were invited to interview. Records showed the interview

process was values based and completed by at least two staff that scored candidates based on their answers. The provider had introduced literacy and numeracy assessments to ensure that staff had the skills required to perform their roles. Following a successful interview the provider used an external company to collect references and check employment history details provided. The provider ensured staff had undergone a recent criminal records check to ensure they were suitable to work in a care setting. The provider completed checks to ensure staff had the right to work in the UK including checks of applicants' identity. This meant the provider had ensured they had recruited suitable staff. People, relatives and staff told us there were enough staff. Both people using the service were supported by two staff. One person received 24 hours care support from two staff and the other person was supported by two staff during the daytime and at night by a floating staff member who also provided support to people residing in supported living flats. We looked at staff rotas that confirmed people received appropriate staffing support.

The provider's medication policy gave detailed guidelines to staff on medicines storage, prescribed, homely and "as and when" required medicines administration, recordkeeping and disposal, and staff training. Staff that administered medicines were trained in medicines administration and their competency assessed, records seen confirmed this. The team leader told us, "I implemented medicine competency assessments. It makes my staff research and fill out the information. I discuss in supervision. I do observation with them and observe after training. [Observations] are kept in the manager audit [folder]." Staff were aware of how to support people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when required for specific situations. A staff member told us they followed people's individualised PRN protocols when people displayed behaviour that challenged the service. They further said, "PRN is offered only after using positive verbal techniques and if they do not work and if the customer [person using the service] is posing danger to himself and others, then speak to the team leader or the registered manager, get a second opinion and then administer PRN." Records seen confirmed PRN medicines had been administered and signed for as prescribed.

People's medicines administration records (MAR) showed two staff were not always signing MAR as per the provider's policy and procedures. However, we found these errors were identified by the management and staff were booked on a medicines refresher training course. There were systems in place to assess staff competencies following refresher training to ensure they were following appropriate medicines recordkeeping procedures. We saw staff maintained records of medicines that were sent with the person when visiting their parents.

People's medicines were securely stored in lockable medicines cupboard in their flats and only accessed by staff administering medicines. Medicines cupboard temperature logs showed they were maintained at the recommended level to ensure medicines were effective. Staff counted medicines at the end of each shift and this information was shared during staff handovers. The provider followed appropriate medicines procedures to ensure people received their medicines at the right time from staff that were suitably trained and competent.

Staff followed safe infection control practices including wearing gloves to ensure people were protected from cross contamination and spread of infection. People's bedrooms and communal areas including the garden were clean and did not have malodour. Staff carried out regular bedroom health and safety checks and although there were no concerns we found there were some gaps in the checks. The registered manager told us they had not audited the checks yet and hence had not identified the gaps.

The provider carried out regular premises health and safety, fire, water and maintenance checks and records seen confirmed this. We looked at people's personal emergency evacuation plans (PEEP) and found they were individualised and in date. Staff knew people's PEEP and how to support them in case of fire

emergency. On the day of inspection, there was no paperwork confirming that the fire extinguishers had been serviced since June 2016. Following the inspection, the provider sent us fire extinguishers inspection certificate that confirmed the equipment had been serviced on 16 February 2018.

The provider had a comprehensive incident management policy that informed the management and staff on how to report, record, monitor and manage incidents. The provider's accidents and incidents records were clear and gave sufficient information on the incidents, investigation, and actions taken to prevent future occurrences. The provider carried out a yearly incidents analysis that gave information on type of incidents, where and when they occurred. The registered manager told us this analysis enabled them to learn from the incidents and improve practices to decrease the occurrence of incidents. The analysis for December 2016 to November 2017 showed that the overall trend for incidents had decreased from the previous year. The registered manager told us together as a team they learnt from incidents and complaints, and shared the learning during team meetings and handover sessions.

Is the service effective?

Our findings

A person and a relative told us staff were well trained and supported people well. One person said, "Oh yes, staff supports me well. My needs are met." A relative commented, "Staff are trained and support him with his needs. He is looked after well."

People's needs were assessed before they moved to the service. The registered manager and the team leader together carried out people's needs assessment to ensure they were able to support people with their individual needs. They involved people, their relatives, and relevant healthcare professionals in the assessment process. One relative said, "Oh yes, I was involved in the assessment, they [the management] carried out a comprehensive assessment." During the needs assessment process, the management sought information on people's health, mobility and medical needs and abilities, communication needs, their care and treatment, preferences and requirements. Staff were aware of people's individual needs and abilities and how to meet those needs. Staff told us they worked well together as a team and supported each other to deliver effective care.

New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. When new staff joined the service they completed a comprehensive induction programme which included two weeks of shadowing experienced staff, records seen confirmed this.

The staff training matrix and records showed staff completed a range of training courses appropriate for their roles including safeguarding adults, health and safety, fire safety, medicines, manual handling, equality and diversity, food safety and nutrition, lone working and personal safety, infection control, first aid and personal care. Staff also completed training specific to the needs of the people they were caring for. This training included autism, Positive Behavioural Support, managing challenging behaviour, epilepsy, diabetes awareness and Maybo. Maybo is a conflict management training which is required in certain roles to help staff to effectively manage aggressive and challenging behaviour. Staff told us they received the training they needed to provide effective care. One member of staff said, "The training is quite good. [Provider] gives out a lot of information on autism in training." Another staff member commented, "I have received a lot of training, it is good and get refresher training in medicines, safeguarding, health and safety."

There was an effective supervision and appraisal system in place. Staff told us they were provided with one to one supervisions. The supervision sessions enabled staff to discuss their training and development needs. Records showed actions from previous supervision sessions were discussed. Areas discussed were training, health and safety, care files, medicines, finances, key working, care plans and risk assessments, and updates on people who used the service. A staff member commented, "I get to voice out. [Talk about] what my training needs are for me." Another staff member said, "Supervisions are healthy and useful."

People were supported to maintain healthy balanced diets and told us their nutrition and hydration needs were met. The provider involved people and their relatives where required to develop their nutrition plan. Staff were aware of people's dietary needs and supported them accordingly. Generally, people's daily care

records included information on what people ate and drank. As a good practice the provider weighed people on a monthly basis. Where people's nutrition and hydration assessments outcome was to lose or gain weight, their weights were monitored weekly. Records seen confirmed this.

Staff supported people to access healthcare services to ensure they received ongoing healthcare support and people confirmed this. There were records of correspondence confirming people were well assisted to receive ongoing healthcare support such as medicines reviews, hospital checks, admission and discharge letters and dentist appointments.

A person told us they liked their flat and enjoyed using the garden space. One relative commented, "He loves his flat, it is his space." The provider used assistive technology in people's flats to monitor people's movements and any unusual movement alerted staff in the office which enabled them to take prompt action. Staff were given wrist panic button bands that they could use to call for emergency help.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We 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.

People's care plans made reference to their capacity and detailed information for staff on how to support people with making decisions. There were DoLS authorisations in place and consent forms for care and treatment. People's care records had their photos on them. However, there were no consent forms confirming people and or their relatives had given consent to the use of the photos. The registered manager told us they would follow it up with the relatives and in the meantime they would not use people's photos on their documents and folders.

Staff were trained in the MCA and DoLS, and records seen confirmed this. They were aware of people's right to make decisions and told us they always asked people for their permission before supporting them. One staff member said, "You need to make sure you don't deprive [people who used the service] what they are entitled to. For example, like [person] coming into the communal areas or locking up cupboards." Another staff member commented, "[Person using the service] is on DoLS, means any decisions made on his behalf should be made in his best interest. Yes, still give him choices and encourage him to make decisions around food, clothes, and activities."

Is the service caring?

Our findings

A person told us staff were "caring and helpful." One relative commented, "What staff do is admirable. They are caring, kind and friendly." Relatives visited people regularly and although there were no time restrictions, to ensure people's routines were maintained they pre-arranged their visits with the staff team. A relative told us, "I come here quite often and formed good relationship with staff."

During inspection we observed positive interactions between staff and people. Staff listened to people's requests patiently. They were compassionate towards people's needs and supported them in a sensitive manner. A person said, "Yes, staff listens to me. They are good to me." We saw people were comfortable in their flats and one person showed us around the service and told us they liked living there. Staff talked about people and their needs in a caring manner and told us they found the job rewarding.

People were supported by a regular team of staff to ensure continuity of care, staff rotas seen confirmed this. A staff member commented, "I have been working with [person using the service] on and off for two years. It is important that people have a stable staff team working with them as they do not like changes." They further said working with the same people enabled them to understand their needs better and provide personalised care.

The provider's equality and diversity policy emphasised the importance of treating people equally, celebrating and promoting diversity, and ensuring that discrimination against people and staff due to a 'protected characteristic' does not occur. The Equality Act 2010 protects people against discrimination because of the protected characteristics including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. People's care plans included their cultural and religious needs and preferences, and how they would like to be supported. Staff were trained in equality and diversity, and were aware of their role in ensuring people's human rights were met. A staff member told us, "[Person] is Muslim. So every Friday we take him to the mosque. He will remind you. Strictly halal [food]. It is about equality and diversity." The registered manager told us, "We do recognise our clients have sexual needs. We would respect their views and sexual orientation. We would support and recognise their sexual orientation as their way of life."

A person said, "Yes, staff treat me with respect, they give me privacy." One relative commented, "Oh yes, [staff] treats him with respect and dignity." Staff told us they treated people with dignity and respected their privacy. One staff member said, "I always knock on his door before entering his flat, encourage him to close the curtains when changing clothes, ask him what music he wants to listen, give him choices and treat him like an individual." During inspection, we saw that staff knocked on people's doors before they entered their flats, provided care at people's preferred pace and talked to them politely and respectfully. People's sensitive and personal information was stored securely in lockable drawers in the registered manager's office only accessed by approved staff.

People were supported to maintain their independence and staff encouraged them to do things by themselves that they were able to. For example, tidying their flats, meal preparation and taking dirty clothes

to the washing machine.

Is the service responsive?

Our findings

A person told us staff knew their likes and dislikes and they received personalised care. One relative said the service was responsive and they were involved in care reviews. People were involved in planning their care and the provider carried out regular care reviews. The team leader told us, "Care plans reviewed quarterly and go through at the end of the year. At coffee mornings all relatives [come] and then [I] take out relatives for a one to one [to review their family members'] care plans."

People's care plans were comprehensive and individualised. Staff told us the care plans provided them with enough information on how to provide personalised care. People's care plans included information on their likes, dislikes, wishes, and care support in areas such as personal care, nutrition, medicines, mobility, accessing the community, activities, cultural and religious preferences. For example, people's care plans stated what was their preferred name, how they wanted to be supported in the community, their favourite food and drinks. The provider developed people's 'one page profile' to give staff information pertinent to people and their healthcare and support needs. For example, one person's 'one page profile' stated "I am friendly, always willing to try new things, like to meet people. My compact discs and the compact disc player, radio, magazines are important to me. I like going on home visits to see my family. Use positive body language when speaking to me and give me full attention when speaking to me." This showed staff were given information and instructions on how to provide personalised care.

People also had separate health action plans that provided detailed information on how to meet their health specific needs and conditions including epilepsy, choking, and behavioural needs. This meant staff were provided with information on how to support people with their healthcare needs. The provider had developed a 'hospital passport' for people that was sent with them when they were admitted to hospital. The hospital passport is a document designed to give hospital staff helpful information about people that is not only about their illness and health. People's hospital passports were in date and provided information on their communication needs, list of medicines, health conditions and how they were managed, and nutrition and hydration needs.

The provider had been working closely with the local authority positive behaviour support lead in reviewing people's positive behaviour support (PBS) plans. PBS is about ensuring people receive the right support at the right time and to improve the quality of their lives. We looked at people's existing positive behaviour support plans and found they provided staff with instructions on how to support people in the least restrictive way if they displayed behaviour that challenged the staff and the service. These plans detailed triggers and signs and gave clear instructions to staff on measures to take to reduce the occurrence of behaviours that challenged the service. For example, one person's PBS plan stated "Triggers are disruption to routine, poor communication", signs to look for such as "angry facial expression, threatening gestures such as pointing, raising fist" and under the measures to take section the plan stated "Use positive body language, give full attention when talking to [person using the service], encourage to access a quiet area where the [person using the service] can relax." This showed people received personalised care that was responsive to their needs.

Staff assisted people in developing their weekly activity plans and with activities of their choice. People's weekly activity plans included leisure, daily living skills, fitness and religious activities. For example, one person's weekly activity plan included activities such as exercise in the garden, swimming, walking in the park, using the gym, flat management, laundry, food shopping, visiting the library, art and craft, colouring, painting, board games, religious place visits, phone calls to family and family home visits. One person told us they had designed their activity plan with the help of staff and enjoyed all the activities. They commented, "Every morning I run in the garden. I like listening to music, shopping for CDs and clothes." On the inspection day, we saw people enjoying activities as per the weekly activity plan such as colouring activity and visiting family.

The provider had recently introduced key working sessions where staff supporting people met with them once a month to discuss their activity plans, skills they have and would like to develop, any concerns, any changes required and produce an action plan. For example, one person's key working session stated they would like to improve their money skills and would like to be able to identify different coins and notes. We saw records confirming an activity session had been carried out with the person to learn about different coins and notes, and the person was able to identify them accurately. The person had commented that it was very interesting to take part in the session. This showed people were supported with a range of activities as per their wishes.

The provider encouraged people and their relatives to raise concerns and complaints. A person said they spoke to the registered manager if they were not happy about something or wanted to make a complaint. A relative told us they had raised a concern regarding a staff member using their mobile phone. They further said that the registered manager investigated the concern and wrote to them with the outcome. We saw investigation notes, records of the outcome and correspondence. This demonstrated the provider listened to people and their relatives' concerns and complaints and acted on them in a timely manner.

The provider had an end of life policy that described how to support people with their end of life care wishes and preferences. Staff were aware of this policy but did not have any one that required end of life care support.

Is the service well-led?

Our findings

A person told us, "[Registered manager] is very good, he listens to me. I go to him if not happy." One relative commented, "Yes, [Registered manager] is very good, always popping in and out to see [person using the service] and me. He [registered manager] is hands on, he has done some shifts with [person using the service] so knows him very well. He [registered manager] is approachable."

Staff told us they felt well supported by the registered manager and found him approachable. Staff comments included, "He is very approachable. He is experienced with Nimrod House. Helped me and I learnt quite a lot...He is very hands on" and "I am supported here, yeah, if I need support, I ask the [registered] manager, he is always available." The registered manager told us they felt supported in their role, "[Head of Learning Disability for provider] supports me. She does my supervision. Have meetings once a month to discuss the service and the staff needs."

The provider held monthly staff meetings where staff received up to date information and shared feedback and ideas. Topics at the team meetings included updates on people who used the service, care documentation, activities, medicines, staff rota, health and safety, key working sessions, risk management plans, safeguarding, MCA and DoLS, GP and healthcare access, and people's finances. The team leader commented, "Mostly all my staff attend. Next date is 28 February 2018. I offer to pay to staff not on a shift to come. We talk about service users, health and safety, safeguarding. We throw out questions." A staff member told us they found staff meetings useful.

The registered manager carried out regular audits and checks to ensure the safety and quality of the service. We found most of the times the registered manager had identified gaps and errors in the care records, and areas of improvement. For example, where staff had not signed people's medicines administration records as per the provider's policy they were retrained in medicines administration. There were records of observation carried out following staff retraining to ensure staff were following the provider's policy in medicines recordkeeping. The registered manager had carried out an unannounced visit on a weekend where they found two staff not supporting people as per their agreed care plans. The registered manager discussed the findings at the team meeting and reminded staff of their duties and of the disciplinary policy and procedures. However, they did not keep a written record of this unannounced visit. The registered manager told us going forward they would keep records of future unannounced visits.

The registered manager asked for people, relatives and staff's views to improve the service and took their suggestions on board wherever possible. The team leader commented, "We do coffee mornings with parents. It is a new thing. We will be doing it quarterly. We do tenants meetings and key working sessions. Send out forms to professionals. Get feedback from transforming lead. I oversee complaints but don't get a lot." Minutes of the coffee morning on 15 December 2017 indicated that topics discussed included living environment, care support, improvement areas, activities, support staff, management, CQC report, safeguarding, discussions with families and monthly summaries. The registered manager had recently introduced monthly summaries that were sent out to families at the end of each month to give an update on their relative's health and care. The summaries included updates on medicines, health visits, activities,

relationships, behaviours, goals and diet. A relative told us they felt well informed by the management and their views were listened to "If I suggest something they implement it. They inform me if [person using the service] is not fine."

The provider asked people and their relatives to complete a feedback form every quarter and records seen confirmed this. The feedback was generally positive. The registered manager had written to healthcare professionals requesting their feedback via an annual stakeholder feedback form. They were waiting for their responses.

The registered manager attended the learning disability service managers' meeting across the learning disability services for the provider where they discussed concerns and shared learning to improve the quality of the service. The provider worked with the local authority, the continuing health care team, and other organisations to improve the care delivery.