Southdown Housing Association Limited

Southdown Housing Association - 52 Mill Lane

Inspection report

52 Mill Lane
Portslade
East Sussex
BN41 2DE

Tel: 01273439156
Website: www.southdownhousing.org

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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 November 2018 and was announced. 52 Mill Lane provides accommodation and personal care for up to five adults with severe learning disabilities and physical needs. The house is situated in a residential area of Hove with some shops nearby. The house has been adapted for the needs of the people who live there. Accommodation is arranged on the ground floor, with offices for staff on the first floor.

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

The last inspection on 21 August 2017 identified four breaches of regulations and rated the service as requires improvement. We asked the provider to complete an action plan to show what they would do, and by when, to make improvements. At this inspection on 15 November 2018, we found that staff had followed the action plan and the overall rating for the service had improved to Good.

People were living with a range of complex needs. Risks to people had been identified, assessed and managed. Care plans were comprehensive and provided clear guidance which was being followed by staff to keep people safe. There were enough staff with suitable skills and experience.

Staff understood their responsibilities for safeguarding people from abuse. People were receiving their medicines safely. The home was clean and staff protected people by the prevention and control of infection. Monitoring of incidents and accidents ensured that lessons were learned and improvements were made when things went wrong.

Staff received the training and support they needed to care for people. They understood their responsibilities to gain people's consent for care and treatment. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were receiving the support they needed to have enough to eat and drink. Staff ensured that people had access to the health care services they needed. The home had adaptations that supported people's independence and met their individual needs. The home 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.

People were supported by staff who knew them well. Staff were kind and caring and respected people's dignity and privacy. A relative told us, "The staff are very good. They create a great atmosphere at the place, people are happy there."

People were supported to be involved in decisions about their care and support. Staff were effective in supporting people with their communication needs.

People were receiving a personalised service and staff were focussed on enriching people's quality of life. People were leading full and active lives according to their interests and preferences.

Staff were responsive when people's needs changed and reviewed risk assessments and care plans regularly. Staff were responsive to complaints and feedback.

Management systems and processes were robust and improvements had been made to meet all breaches of regulation that were identified at the last inspection on 21 August 2017. The registered manager provided clear leadership and staff spoke highly of the management of the home. Staff understood their roles and responsibilities and described positive working relationships and good communication both internally and with external agencies.

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 to people were assessed and managed. Incidents and accidents were monitored and potential safeguarding incidents were identified and reported appropriately. Staff demonstrated a clear understanding of how to keep people safe.

People received their medicines safely. There were enough suitable staff on duty for care for people.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective.

Staff received the training and support they needed to be effective in their roles. Staff understood their responsibilities regarding the Mental Capacity Act 2005.

People were supported to have enough to eat and drink. Staff supported people to access the health care services they needed.

People's needs were met by the adaptations and design of the premises.

Is the service caring?

Good

The service was caring.

Staff knew people well, treated them with kindness and respected their dignity.

People were supported to communicate their views about their care and support.

Staff supported people's privacy and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People were receiving a personalised service. When their needs changed staff were proactive in seeking support and reviewing people's needs.

People were supported to lead full lives that reflected their interests and preferences. They were involved in planning their care.

There was a responsive complaints system in place.

Is the service well-led?

Good

The service was well-led.

Quality assurance and governance systems were used to provide management oversight and to drive continuous improvements.

There was visible leadership and staff understood their roles and responsibilities.

Staff had developed positive relationships and worked collaboratively with other agencies.

Southdown Housing Association - 52 Mill Lane

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 15 November 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because it is a small service and we needed to be sure that people and staff would be in. The inspection team consisted of three inspectors.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) before the inspection. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure that we were addressing any potential areas of concern at the inspection.

As people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We 'pathway tracked' two of the people living at the home. Pathway tracking means we looked at people's care documentation in depth and made observations of the support they were given. It is

an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also spoke with one relative of a person who used the service. We spoke with two members of staff and the registered manager and spoke with other staff on duty during the inspection. We looked at a range of documents including policies and procedures, care records for four people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff records including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's management systems.

The last inspection on 21 August 2017 identified four breaches of the regulations.

Good

Is the service safe?

Our findings

At the last inspection on 21 August 2017 some areas of practice were not consistently safe. There was a breach of Regulation 13, safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some incidents had not been identified as possible safeguarding concerns and local safeguarding procedures had not been followed. At this inspection on 15 November 2018 the provider had made improvements to comply with the legal requirements and the breach of regulations had been met.

Incidents and accidents were recorded with the actions that had been taken. For example, an error had been identified when a person's medicine was not given as prescribed. The actions that were taken to address this error were clearly recorded. This included alerting the local authority in line with safeguarding procedures, providing additional training for a staff member and checking their competency before they administered further medicines to people.

Staff demonstrated a clear understanding of their responsibilities for safeguarding people. They were able to describe different types of abuse and to identify possible signs that might indicate abuse. Staff told us that they had received training in safeguarding and described an open culture where staff discussed learning from incidents. Appropriate safeguarding alerts had been made to the local authority in line with the provider's policy and local practice. A relative told us that they believed their relation was safe. They said, "I know they are safe, the staff are very good and they communicate with us openly. I visit very regularly and I would know if something was not right."

Appropriate safeguarding alerts had been made for other incidents, including when staff noticed that people had unexplained bruising. This showed that the provider's systems for monitoring incidents was operating effectively to ensure that people were consistently protected and that there is transparency and proper scrutiny of the service.

At the last inspection on 21 August 2017 there was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always identified, assessed and managed effectively and equipment was not always used safely. At this inspection on 15 November 2018 the provider had made improvements and this breach of the regulations had been met.

People were living with multiple, complex needs and risks had been identified and assessed. There were clear, comprehensive care plans in place to guide staff in how to manage these risks. For example, one person was at high risk of developing pressure sores. Advice from visiting health care professionals had been included within the care plan. This identified clear guidance for staff in how and when to support the person to change position. Pressure relieving equipment had been changed and records showed that a pressure wound had healed.

Some people needed to have their nutrition, fluids and medicines via an enteral feeding system. This is a

flexible tube that enables fluids and liquid foods to be delivered directly into the stomach. There was a clear risk assessment in place which identified specific risks and actions that staff needed to take. For example, there was a risk of infection at the site of the tube. Guidance for staff included clear instructions for care around the site of the tube to prevent infection and instructions for who to contact in the event of any concerns.

Specific risks associated with health conditions had been assessed. Care plans provided clear and detailed guidance for staff. For example, an epilepsy care plan described how a person experienced epilepsy and the assistance they needed. This included a protocol for when specific medicine was needed and guidance for use of magnetic equipment to reduce the severity of a seizure. Staff were using an electronic device to monitor the person's pulse rate which could indicate an imminent seizure. This enabled staff to support the person by reducing the severity of the seizures.

Recruitment checks were completed to ensure staff were safe to support people. These included checks having been undertaken with the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. There were enough staff on duty to keep people safe. The provider used a risk assessment tool to assess the staffing level required at particular times of the day. This was based upon the needs of people living at the home. The registered manager told us that if people's needs changed and more staff were needed this was assessed and additional staff were allocated. For example, additional staff were being used to support people whilst a person was in hospital. This enabled a staff member who was familiar with the person to be at the hospital with them.

People were receiving their prescribed medicines safely. Staff were trained and assessed as competent before they were able to administer medicines. Records were completed consistently. There were safe systems in place for the management, storage and disposal of medicines. Some people had been prescribed medicines to be given PRN (as required). There were clear protocols in place to guide staff in when and how to administer these medicines. For example, one protocol included guidance for staff about when to administer a dose of medicine for someone who was epileptic. The protocol had been reviewed and the care record was updated with clear instructions for staff in how to identify side effects of the medicine and what to do if side effects appeared.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal emergency evacuation plan (PEEP). Contingency plans were in place to respond to any emergencies, for example flood or fire. Infection prevention and control procedures were in place and we observed staff were using appropriate personal protective equipment (PPE) when supporting people with personal care. We noted that all areas of the home were clean and tidy. Cleaning duties were allocated to staff as part of their shift plan and regular checks were implemented around the home to ensure standards of cleanliness were maintained.

Good

Is the service effective?

Our findings

At the last inspection on 21 August 2017 some areas of practice were not consistently effective. There was a breach of Regulation 11, need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not always acted in line with the requirements of the Mental Capacity Act (MCA) and associated guidance. Procedures for administration of medicines had not always considered consent in line with the MCA. At this inspection on 15 November 2018 the provider had made improvements and this breach of the regulations had been met.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff had received training in MCA and demonstrated a clear understanding of their responsibilities. Throughout the inspection we heard staff checking with people before providing care or support. For example, when a staff member was administering medicines to people they explained what the medicine was before offering it to the person. The person's care plan guided staff in explaining that there was medicine on the spoon before offering it.

Records showed that people's capacity to consent to care and support had been considered. For example, some people had been assessed as needing lap belts and foot straps when in their wheelchair to keep them safe. They had been assessed as not having capacity to consent to the use of these restrictive items. Decisions had been made that it was in the person's best interest for these practices to continue. This was clearly documented and identified the people who had been consulted when making this best interest decision.

At the last inspection on 21 August 2017, there was a breach of Regulation 13 safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had been deprived of their liberty without lawful authority. At this inspection on 15 November 2018 the provider had made improvements and this breach of the regulations had been met. DoLS applications had been submitted appropriately. Staff were able to tell us about potential restrictions on people's freedom and knew that people had DoLS authorisations in place. Staff were aware of their responsibility to comply with these authorisations and with any conditions that the local authority had imposed when providing care.

A relative told us that they had confidence in the skills and knowledge of the staff. They said, "I have

absolutely no concerns, the staff know him very well and know exactly what's required." Staff told us that they had access to a range of training that was relevant to their roles. One staff member said, "We each get an e-learning programme each January to complete during the year." They went on to describe other training that was provided including training that was specific to the complex needs of the people they were working with. This included training in administering modified food through the enteral system, training in how to use a suctioning machine to support a clear airway, training in administering specific medicines and in the use of electronic and magnetic equipment to support the management of epilepsy. Records showed that staff had also received specific training in how to support a person with positioning in a sleeping system which enabled them to be supported safely in bed.

Staff described feeling well supported. Records showed that staff were receiving regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues.

There were effective systems to support communication between staff. One staff member told us, "Communication is a strength at the service. We use a communication book, team meetings and supervisions to pass on information." They went on to describe team work at the home saying, "It's an organic process; the registered manager will draft new guidelines and put with the communications book, so everyone has a chance to comment and discuss in team meeting before the final version is agreed."

People's needs and choices had been assessed in a holistic way to take account of people's physical and mental health and their social needs. Appropriate assessments were undertaken to identify how to achieve effective outcomes for people. For example, tools were used to provide evidence based assessments of people's needs including for assessing the risks of malnutrition.

Assessments and care plans were comprehensive and provided clear guidance for staff in how to achieve good outcomes for people. Staff were following guidance in care plans, for example, one person's care plan guided staff to offer two boxes of cereal so they could indicate their choice by touching one box. We saw staff using this method to support the person.

People were supported to have access to health care services when they needed to. Records showed that staff supported people to attend regular appointments. For example, people were attending regular health check ups including with their GP, dietician and dentist. When people's needs changed staff were proactive in seeking advice from health care professionals. People's care plans included advice from health care professionals. Guidance for staff was updated following appointments and visits.

People's nutritional and hydration needs were assessed and risks were identified and managed. Some people needed modified diets due to risks of choking. Speech and Language Therapist (SALT) advice was included within care plans. For example, one person needed to have their food liquidised. Their care plan included information about how the person preferred to see what food was on their plate before it was liquidised and this enabled them to make choices about what they were eating. We observed staff supporting the person in this way during the inspection. People were encouraged to make choices about their food and we saw people being involved in cooking their own lunch. Records showed that staff were monitoring people's weight when risks had been identified. When staff were concerned about changes in people's weight or their appetite, records showed that they had made appropriate referrals to seek advice. People were being supported in the way that was most appropriate for them.

The home had adaptations to meet people's needs. Equipment was available throughout the home to

support people to move around and to access baths and showers. People were able to access all areas, including the garden and could move around their accommodation without obstruction. People's diverse needs had been considered. For example, one person spent much of their time at a low level and equipment in their room, including their television, had been lowered to support their needs. Underfloor heating had been installed in their bedroom as they liked to spend time on the floor.

The Care Quality Commission's Registering the Right Support (RRS) and other best practice guidance, describes how people with learning disabilities and/or autism are as entitled to live an ordinary life as any other citizen. The values underpinning this policy include offering people choices, promoting independence and inclusion within the local community. Although 52 Mill Lane was registered before this guidance was published, the model and scale of the home are in keeping with the RRS principles. The home is small and provides a homely environment. People have access to local amenities and were supported to participate in the community. People were able to use local health and social care services and staff supported people to be independent.

Good

Is the service caring?

Our findings

People continued to be supported by staff who were kind, caring and compassionate. We saw that people were comfortable with staff and had developed positive relationships with staff who knew them well and understood their needs. A relative told us, "The staff are very good. They create a great atmosphere at the place, people are happy there."

Staff spoke about people with compassion and respect. One staff member told us, "I love working here. The people are wonderful." The staff member described working with one person and said, "They are really good fun to be with, they like to tease staff sometimes by asking for things that they don't really want then laughing. They have a fantastic sense of humour." We observed staff treating people with respect, offering gentle reassurance in a kind manner.

Staff were attentive to people and observant regarding how they might be feeling. For example, one person was sitting in the lounge and staff told us they did not enjoy noisy environments. A staff member noticed a change in their body language when it became noisy in the adjoining kitchen area and they immediately checked how the person was and closed the door to ensure their comfort.

Staff supported people to be as involved as possible in expressing their views and in making decisions about their care and support. For example, the registered manager said that prospective staff were asked to visit the home to meet people. Observations of how people were interacting with prospective staff informed the recruitment process.

Staff used a number of methods to break down barriers to communication. Staff were skilled at interpreting non-verbal communication because they knew people well. One person communicated with staff using facial expressions, noises and pointing with their eyes. Staff were using Makaton signs and symbols with some people. Makaton is a language programme using signs, symbols and speech to help people to communicate.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The registered manager was not aware of the AIS, however staff practice complied with the standard. All the people living at the home had communication needs due to their disability or sensory loss. Records clearly identified and flagged people's communication needs. Communication care plans were in place to guide staff in how to support people. For example, one care plan described the methods of communication that the person used including verbal communication, Makaton, objects of reference and pictures. Care plans were comprehensive but provided clear, personalised information. For example, identifying what certain gestures meant, identifying particular actions and their meaning and reminding staff to use one information carrying word at a time. Staff were observed using all these methods with the person during the inspection. People had communication passports designed to share information with other people about their individual communication needs. Staff said these were useful, for example if people needed to go into

hospital.

People were supported to be as independent as possible. Staff told us they focussed on how to support people to make choices and do as much as they could for themselves. For example, one person was offered a drink and staff brought the kettle to them to turn on. Another person had adapted cutlery and staff supported them to bring the food to their mouth successfully so that they retained their independence. We noted that when the person became tired the staff member adapted their technique so that the person could continue to bring the food to their mouth independently.

Staff were mindful of protecting people's privacy. Personal information was kept securely. Staff were discreet when discussing people's needs to ensure their privacy and dignity were protected. People were able to spend time alone when they wanted to. This was reflected with clear guidance for staff in how to recognise when people wanted privacy. We noted staff following guidance in care plans during the inspection and ensuring that people had time to themselves.

Good

Is the service responsive?

Our findings

Staff continued to be responsive to the needs and preferences of people. A relative told us that staff knew their relation well and understood their needs. They said, "The staff communicate with us frequently. We are kept informed of any changes and are always involved." A staff member confirmed this saying, "We involve family members a lot and have got very positive relationships with them."

Records confirmed how staff ensured people were able to contribute to planning their care and support. A staff member explained, "It's a priority for us that we help people to achieve the best quality of life. We have to do all we can to identify what they want and enjoy and then we can help them to achieve their goals. We do a lot of preparation for review meetings so they are as involved as they can be." Care plans were developed in accessible formats that were appropriate for each person's communication needs. For example, one care plan included photographs of the person taking part in leisure activities such as swimming, visiting a coffee shop, walking along the seafront and spending time with their family. A staff member told us that the person was able to indicate what their preferences were using photographs. Another care plan guided staff to use objects of reference to support the person to communicate their choices. For example, showing them their coat to ask if they wanted to go out.

People's differences were acknowledged and respected. Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender and sexual orientation. These needs were recorded in care plans and all staff we spoke to knew the needs of each person well. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. One person had a fish tank in their room, another had sensory lights. Staff knew people well and were knowledgeable about their preferences, likes and dislikes. One person's care plan described their enjoyment of music and we saw staff supporting them to use an electronic keyboard. Another person enjoyed gardening and showed us photos of their achievements. People were supported to use technology. For example, one person was supported to enjoy music through use of an electronic tablet.

Support plans placed a clear emphasis upon the individual's strengths, abilities, independence and their overall quality of life. They provided staff with detailed guidance about what was most important to people, including their likes, dislikes, hobbies and interests, and their preferred daily routines. People's different interests were identified and planned. Staff were focussed on supporting people to achieve goals that were meaningful to them. One staff member described the challenges of supporting a person who had sensory loss and communication difficulties. They explained how staff had noticed the person's reactions to certain sounds and smells and were looking at how they could incorporate these sensations into the person's care plan to support their communication. We noted that the planned communication project had been discussed at a recent team meeting and staff were clearly excited about trying some of the techniques.

Staff were skilled at identifying changes in people's needs and records showed that appropriate actions were taken, such as referrals to health care professionals when needed. Risk assessments and care plans were reviewed regularly and when people's needs changed. This meant that staff had accurate information

about how to provide care in a personalised way.

Care plans were comprehensive and detailed. Staff told us this helped them to provide person centred care. One staff member said, "I feel well aware of the content of support plans. They are all very individual. Any changes are indicated in the communication book but we use the actual plans a lot." Our observations throughout the day confirmed that care was provided in line with the detailed guidance contained in care records.

Staff had recognised that some people needed support with behaviour that could be challenging. A staff member told us, "We have identified some triggers for the behaviour, for example, if they are uncomfortable in their clothes or shoes or don't want to do something. They will express this in their behaviour." Staff had received training in Positive Behaviour Support (PBS). This is a person-centred approach to people with a learning disability and/or autistic people, who display or at risk of displaying behaviours which challenge. It involves understanding the reasons for the behaviour and considering the person as a whole, including their life history, physical health and emotional needs, to implement ways of supporting the person. People had PBS plans which included tools for assessing distress and guidance in how to support the person. Staff told us that the provider had their own PBS worker who supported staff to develop effective plans tailored to people's individual needs and circumstances.

People were not receiving end of life care at the home. However the registered manager told us that staff had made strong links with health care professionals and felt confident that staff would be able to support people with end of life care if required. They described how plans would be made to ensure that people's needs were met in a person centred way.

The provider had a complaints system in place but no complaints had been received. The registered manager said that they had regular contact with people's relatives and any concerns they raised were dealt with straight away. Quality assurance systems included a satisfaction questionnaire. We noted that some concerns had been raised by a relative through this process. The registered manager had undertaken an investigation into their concerns and a written response had been sent by the Operations Manager. A relative told us that they would feel comfortable to raise any complaints with the registered manager. They told us, "Any of the staff would sort out any issues. I have spoken to the registered manager about one issue and it was dealt with straight away."

Good

Is the service well-led?

Our findings

At the last inspection on 21 August 2017 some areas of practice were not consistently well-led. There was a breach of Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because management systems were not effective in monitoring and improving the safety of services and mitigating risks. At this inspection on 15 November 2018 the provider had made improvements to comply with the legal requirements and the breach of regulations had been met.

The provider had a number of quality assurance processes in place to identify any shortfalls in the quality of the service. This included systems to audit and review governance arrangements and to support improvements and developments at the home. For example, a medicines audit had identified the need to update and improve a medicine protocol to include what actions staff should take if a person developed signs of side effects from the medicine. We noted that this protocol had been updated. Action plans were developed from internal and external audits. This showed how improvements were made and described the actions taken with the timescale for completion.

Management systems provided oversight for the registered manager. For example, there was a system in place to monitor staff training and identify when refreshers were needed. Incidents and accidents were monitored and analysed to identify patterns and trends. The registered manager used this information to make changes to improve risk management. For example, specific guidance had been included within a care plan to provide additional guidance for staff.

At the last inspection on 21 August 2017 there was breach of Regulation 18, notification of other incidents, of the Care Quality Commission (Registration) Regulations 2009 (Part 4). This was because the provider had failed to submit a statutory notification about people's temporary move from the home when renovation work was undertaken. At this inspection on 15 November 2018 the provider had made improvements to comply with the legal requirements and the breach of regulations had been met.

Services that provide health and social care to people are required to inform us of important events that happen in the service. The manager had informed us of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Since the last inspection the manager had become the 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.

Staff spoke highly of the management and leadership at the home. One staff member said, "The main thing

is how good the manager and seniors are. The success of the home all comes back to good leadership." A relative also told us that they had confidence in the registered manager.

There was a clear management structure and staff demonstrated that they understood their roles and responsibilities. A staff member said, "The manager is very clear about what they want from us, and are hands-on." Another staff member told us about their role as a key worker. The key worker system enabled people to have a named member of the care staff to take a lead and special interest in the care and support of the person. They explained that they had certain responsibilities including to track people's every day needs and appointments and to ensure records were updated, such as regular checks on people's weight.

Staff described an open and transparent culture at the home. One staff member said, "If things go wrong we discuss it as a team and work out solutions." Staff said their ideas were welcomed and they felt confident to raise suggestions. They described engagement with developments at the home. For example, one staff member told us, "I devised a simple form for tracking medical appointments to ensure things get booked." Records of staff meetings showed that staff were involved in suggesting new ways of working and identifying improvements to further enrich people's lives.

Staff had developed links with the local community and people were supported to access community facilities. A staff member told us about people's preferences for visiting a particular local café, shops and a garden centre. A relative commented that their relation was often "out and about" in the local community.

Staff described positive working relationships with visiting health care professionals. Staff worked collaboratively with other agencies and shared relevant information appropriately. For example, staff were working closely with staff at the local hospital to support a person who had been admitted.