NE Lifestyles Limited

Kibblesworth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 28 June 2017.

This was the first inspection of Kibblesworth since it was registered with the Care Quality Commission in September 2016.

Kibblesworth is registered to provide care and treatment to a maximum of 16 younger adults aged 18-65 with complex physical care needs, as a result of acquired brain injuries. At the time of inspection 14 people were using the service.

A manager was in place who was in the process of registering with CQC. 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 and people said the management team were approachable. They were positive about the changes that were being made within the home. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

Training was provided and staff were supervised and supported. Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about most aspects of their daily lives. People received a varied diet to meet their nutritional needs. However, people were not all encouraged to make choices with regard to their food and people's dining experience required improvement.

Risk assessments were in place that accurately identified current risks to the person. However, we considered a more robust risk assessment needed to be in put place for any person who smoked. This was addressed immediately to ensure people were kept safe. People's privacy and dignity were respected. Records were in place that reflected the care that staff provided. People said staff were kind, patient and caring. However, we saw staff did not always interact and talk with people when they had the opportunity. We have made a recommendation about person centred care provision.

People were protected from the risk of abuse as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. There were enough staff available to provide individual care to people. Activities and entertainment were available for people and people were being consulted to increase the variety of activities and outings.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems

were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the management of medicines.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. The service had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received individual care that met their needs.

People had the opportunity to give their views about the service. They were supported to maintain some control in their lives. There was consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

Risk assessments were up to date and identified current risks to people's health and safety. However, a more robust risk assessment was required for the issue identified at inspection. People received their medicines in a safe way. However we have made a recommendation about medicines management.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring and mostly respectful. People said the staff team were kind and patient. However, staff did not always engage with people and interact with them when they had the opportunity. We have made a recommendation about person

centred care.

People were encouraged and supported to be involved in daily decision making. However, systems for people to choose their food required refining. Improvements were required to people's dining experience.

Staff were aware of people's backgrounds and personalities. Staff were aware of people's needs and met these in a way that respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. Records were up-to-date and reflected people's current care and support needs.

There were activities and entertainment and the programme was being extended to stimulate and engage people. There were opportunities for people to contribute and be part of the local community.

People had information to help them complain.

Is the service well-led?

Requires Improvement

The service was well-led in most areas.

A manager was in place who was in the process of registering with CQC. A limiter is put in place that restricts the domain being rated as good until the manager of the service is registered with the Care Quality Commission."

Staff and people told us the manager was available to give advice and support. They were complimentary about the changes that were being made in the home.

Improvements were being made by the provider and were being maintained by the manager and management team to promote the delivery of more person centred care for people.

The manager monitored the quality of the service provided to people. However, we considered improvements were required to the quality assurance process to ensure that people received personalised care that met their needs in the way they wanted.

Kibblesworth

Detailed findings

Background to this inspection

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

This inspection took place on 28 June 2017 and was unannounced. The provider submitted further written evidence on 3 July 2017 which was used as part of the inspection. The inspection team consisted of one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for younger people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 service as part of 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 CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

During the inspection we spoke with seven people who lived at Kibblesworth, the manager, the director of operations, the provider, an occupational therapist, one registered nurse, eight support workers including one senior support worker and one member of catering staff. We looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for four people, recruitment, training and induction records for five staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable with staff support. One person commented, "Staff watch out for me." Another person said, "I really like it here, staff offer me comfort and this makes me feel safe." A third person told us, "Staff know what to do to keep me safe." Other peoples' comments included, "I feel safe and independent here, I can go out by myself" and "Staff are a good support to me, they know who I am and what I'm about and make me feel safe."

The manager told us staffing levels increased depending upon the needs of the service. A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in activities of daily living. The dependency formula was then used to work out the required staffing numbers. For example, more staff would be rostered if people were attending hospital appointments or going out.

We considered there were sufficient staff to meet people's needs, however they needed to be kept under review as people's needs changed. Some people's comments did not maintain there were sufficient staff. We discussed this with the manager who told us there were staff vacancies but these hours were being filled by current members of staff, to maintain continuity of care, or bank staff. They said they would also ask people for feedback about why they thought there were not enough staff. One person told us, "Staff don't always respond to me at short notice." Another person commented, "We are short staffed." A third person said, "I definitely need more attention from staff and I won't get this until more staff are recruited here." Other comments included, "The ratio of nurses to people means you have to wait too long to be seen", "I would give the home nine out of ten, with more staff I'd give it ten."

There were 14 people living at the home at the time of inspection. Staffing rosters and observations showed people were supported by one registered nurse, a team leader and five/six support workers during the day and evening. An additional member of staff was also on duty in the evening between 6:00pm and 12:00am. Overnight staffing levels included one registered nurse and two support workers. These numbers did not include the manager who was also on duty each day and operated an on-call arrangement overnight for emergency advice or support.

The provider had procedures in place for safeguarding people and staff had a good understanding regarding safeguarding and knew how to report any concerns. They expressed confidence that the manager would respond to and address any concerns appropriately. They were able to describe various types of abuse and had received training related to safeguarding vulnerable adults. One staff member told us, "I'd report any concerns to the manager or my team leader and complete a body map." (A body map is used to record and monitor any injuries observed on a person.)

We noted a person smoked in their bedroom, although they had been advised not to. Guidance was available for staff in a behavioural care plan that detailed action to take to minimise the risk. However, a separate risk assessment was not available that immediately highlighted the risk of smoking in the bedroom. This was addressed straight after the inspection and we received a risk assessment, that provided guidance to staff to minimise the risk. Other risk assessments were in place that were regularly reviewed and

evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care, choking and nutrition. Referrals were made where problems had been identified. Staff meeting minutes showed, the provider had identified all people should have a reviewed risk assessment with regard to falls and this had been carried out.

Regular analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, incidents of distressed behaviour would be referred to the relevant professionals.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour support team and the community mental health team. Staff told us they followed the instructions and guidance of the teams, for example, to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. All medicines were appropriately stored and secured.

The registered nurse told us medicines would be given outside of the normal medicines round time if the medicine was required. Such as for pain relief or for agitation and distress. General written guidance was available for the use of "when required" medicines, as part of the medicines policy. Guidance was available in people's care plans, which provided staff with a consistent approach to the administration of this type of medicine and when it should be given.

Records for one person referred to the use of covert medicine.(Covert medicine refers to medicine which is hidden in food or drink). Records showed that most of the relevant people had been involved in the 'best interest' decision making. However, the pharmacist had not been involved. National Institute for Health and Care Excellence (NICE) guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests." The registered nurse told us that this would be addressed.

We recommended the service considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

A personal emergency evacuation plan (PEEP) was also available for each person taking into account their mobility and cognitive awareness. This was if the building needed to be evacuated in an emergency.

The provider had arrangements in place for the on-going maintenance of the building and two maintenance people were employed. There were appropriate emergency evacuation procedures in place, regular fire drills had been completed and all fire extinguishers had been regularly serviced. An up to date fire risk assessment was in place for the building. Records we looked at included, maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety

checks. Regular checks were carried out and contracts were in place to make sure the building was well maintained and equipment was safe and fit for purpose.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. Relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with people who used the service.

Good

Is the service effective?

Our findings

Staff told us and training records showed they were kept up-to-date with safe working practices and received other training to give them more insight into any specialist conditions to meet people's support requirements. One staff member told us, "I've done all my mandatory training and there always opportunities for other training." Another staff member commented, "I'm up to date with my training." A third member of staff said, "I've done acquired brain injury training."

Staff members were able to describe their role and responsibilities. Staff told us when they began work at the service they completed an induction and they had the opportunity to shadow a more experienced member of staff. One senior commented, "I received my induction training and role specific training at head office." The area manager said all senior staff received a company induction at head office. The staff training matrix showed staff studied for the Care Certificate as part of their induction training and existing staff members also completed this training. This made sure new staff had the basic knowledge needed to begin work. The staff training records showed refresher training was being carried out so staff were kept up-to-date with safe working practices.

There was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, Huntingdon's disease, introduction to brain injury, equality and diversity and dementia care and positive behaviour training so staff were clear about how to meet each person's individual needs. We noted the staff training matrix did not show people had received stand alone training about the Mental Capacity Act 2005 and associated deprivation of liberty safeguards. Staff told us they received this training as part of the Care Certificate they studied. Several staff members had completed National Vocational Qualifications (NVQ) at levels two and three. (This qualification is now known as the diploma in health and social care.)

A supervision system was in place for staff to receive regular supervision from the management team, to discuss their work performance and training needs. Staff told us they could also approach the manager and senior staff at any time to discuss any issues. One staff member told us, "I'm due a supervision, the team leader will do it." The director of operations told us staff received a six monthly appraisal to review their work performance.

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 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. The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We were informed by the manager 10 people were currently subject to such restrictions.

The service worked within the principles of the MCA and staff were aware of the implications for their practice. Consent was obtained from people in relation to different aspects of their care, with clear records confirming how the person had demonstrated their understanding. Mental capacity assessments had been carried out, leading to decisions if required, being made in people's best interests.

Staff told us communication was effective to keep them up to date with people's changing needs. One staff member told us,"There's a handover at the start of every shift." Another staff member told us, "There is good communication." A third member of staff said, "We get a detailed handover that tells us how people are and specific needs will be discussed." A verbal handover session with written information took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. Staff told us a communication book was also used that they read when they came on duty. This was to ensure staff were made aware of the current state of health and wellbeing of each person.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was stocked with fresh, frozen and tinned produce. We spoke with the new chef who was very enthusiastic and was introducing changes to menus to make them more varied, healthy and personal to people. The chef was aware of people's different nutritional needs and special diets were catered for. They said people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They received information from nursing staff when people required a specialised diet. People commented positively about the food. One person told us, "There's lots of choice with food now, more than in the past. It is better than restaurants." Another person said, "Meals are nice." A third person commented, "The food is good since we got [Name], the new chef. He's good at cooking things."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidents of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, behavioural support team, dietician and a speech and language team (SALT) Care plans reflected the advice and guidance provided by external professionals. The provider employed an occupational therapist who had just started worked with the service. They commented, "Part of my role is to support and implement rehabilitation programmes." We observed an immediate change they had made within the service. For example, they had seen someone using the through floor lift had some difficulties, as they were unsure of the buttons to press once inside the lift. The occupational therapist had provided signage and marked the buttons to point out the direction of travel and the person could now access their bedroom independently.

Requires Improvement

Is the service caring?

Our findings

People who used the service were positive about the care and support provided. One person told us, "Staff do care about me." Another person commented, "Staff are nice and caring. They see that I have money in my pocket and that makes me feel good and gives me power." A third person said, "Staff are patient and realize how important it is for me to visit my family." The atmosphere in the home was calm and friendly. People were spoken with considerately and we observed people were relaxed with staff.

However, from our observations we considered improvements were needed to ensure people received more person-centred care and staff interacted with people.

Some staff acted in a supervisory role and did not interact with people, they stood over people as they talked amongst themselves. On occasions we observed as two staff members were supporting a person they would talk over them and not include the person in their conversation or acknowledge them. We saw staff did not take the opportunity to engage and interact with each person and encourage their awareness and interest in their surroundings. They did not talk to people and spend time listening to what they had to say. We noted some people, who made themselves known to staff, received more attention than other people during the day and at the lunchtime meal. One person told us, "Staff are patient, but they are sometimes looking over their shoulder, for other people around them, so I can't retain their full attention." Another person said, "I could do with some more attention from staff." The registered manger told us staff had been reminded about not talking amongst themselves. Staff meeting minutes also recorded that staff had been asked not to talk amongst themselves or over people when out in the minibus but to include people in the conversation and engage with them. We discussed that training about person centred care and about the rights of people should help address this.

Most people congregated and were supported or remained in the large combined lounge and dining room throughout the day. We observed the dining room walls contained notices, posters and lists more appropriate for an office or staff room which were more relevant to staff rather than making the décor more homely for people. The manager told us that this would be addressed and they also discussed the plans for making a separate lounge and dining room rather than one large room, this would help personalise the environment and make it more homely.

People were encouraged to make some choices about their food. However, we considered some improvements may be needed. We were told people ordered their individual meal choices the week before. We discussed with the manager that people may not always want the meal choice they had made the previous week. People with memory issues may also not recall their choices. The manager told us that this would be addressed however people could have an alternative meal on the day.

We observed the lunch time meal in the dining room and considered that improvements were required to the organisation of people's dining experience. The meal time was unhurried but people did not sit down together and have their meal served at the same time. Tables were not set with tablecloths, napkins and condiments and cutlery was not available for everyone, cutlery was collected whilst people waited.

Individual meals were prepared in the kitchen, heated in a microwave and staff carried meals of uncovered food from the kitchen to the dining room. Trays of uncovered food were also carried to people who were served their lunch in their bedroom. People had to wait and left the tables as other people were served. A menu to help inform people about the food was not available on each table. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. For example, "Is that enough" and "Do you want a drink now?" The meal time organisation was discussed with the manager who told us it would be addressed immediately. After the inspection the manager told us a heated trolley had been obtained so people could be served at the same time.

We recommended that the service finds out more about training for staff, based on current best practice, in relation to person centred care.

People told us their privacy and dignity were respected. One person said, "I don't talk to people very much here, I keep myself to myself, and staff respond well and respect that." Another person commented, "I often spend a lot of time on my own and my privacy and dignity is respected by staff." We observed that people looked clean, tidy and well presented.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing or two plates of food. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Care plans provided information about how people communicated. For example, one care plan recorded, '[Name] is able to support their communication with hand movements and when prompted will slow down and communicate their needs to make it easer to understand." This information was available for staff to provide guidance about how a person should be supported.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. Emergency health care plans were in place for some people. The care plan detailed the "do not attempt cardio-pulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told one person had the involvement of an independent mental health advocate(IMHA) to help assist with holiday and travel plans for the person.

Good

Is the service responsive?

Our findings

Most people commented there were activities and entertainment available. One person told us, "I've often requested more things to do and had a good response from staff, I now get involved in gardening and painting." Another person commented, "The home is great for watching dvds." A third person said, "I enjoy a takeaway meal on Friday." Other peoples' comments included, "I don't like the activities they do here much, sometimes there's nothing going on", "Staff do care about me and they try to get me involved in activities but I'm not bothered" and "There's nothing to do here, I just sit around all day long, but staff oversee I'm okay." The manager told us activities were being addressed and the resident agenda and staff meeting minutes showed that people were being consulted for ideas about what they would like to do on an individual and group basis.

Staff told us each person was allocated a day to choose what they would like to do on that day. We saw the chef carry out a cooking session with two people who were very proud of what they had cooked and were very much looking forward to their next cooking session, later in the week. The chef also told us about the gardening project and herb garden that had been introduced for people to take part in. The home had transport and people were supported to go out individually or in groups to the coast, countryside and retail shopping centres. People told us they went out for meals, shopping, swimming, football matches and concerts. Seasonal parties and entertainment also took place.

People were supported to go to work or attend day placements. One person told us, "The staff have been effective in making sure I do a job I like and learn from it."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Records showed preadmission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Care plans provided some instructions to staff to help support people to learn new skills and we discussed that they should be broken down into tasks so staff were aware of the support they had to provide and what the person could do to maintain or regain some independence. One person told us, "Staff support my independence." Another person commented, "I feel independent, I can go out by myself." A third person said, "Staff have been very effective in helping me to be more independent, this has improved with the change of management recently."

We were told there were plans for the occupational therapist to co-ordinate programmes of rehabilitation with some people to help them move to more independent living. We discussed that records would provide instructions for staff to help people acquire the necessary daily living skills to become more independent.

A daily record was available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and

when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records were being up dated to ensure they were personal to the individual. They contained information about people's likes, dislikes and preferred routines. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. People said they were involved in discussions about their care and support needs. One person told us, "I know about my care plans." Another person said, "I think I should be involved in the care plans for my own interest."

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. One person commented, "Staff know how important it is for me to visit my family." Another person told us, "Staff care for me and my family, I visit my Dad."

Meetings were held with people who used the service. The manager said meetings provided feedback from people about the running of the home. A new standard format was being introduced for the agenda and it showed monthly agenda topics included activities and menus.

People knew how to complain. People we spoke with said they had no complaints. One person told us, "If there was a problem with anything I could sort it out with management no problem." The complaints procedure was on display in the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated.

Requires Improvement

Is the service well-led?

Our findings

A manager was in place who was in the process of registering with CQC. A limiter is put in place that restricts the domain being rated as good until the manager of the service is registered with the Care Quality Commission.

The manager and director of operations assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The manager and director of operations were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

During the inspection we met the provider who told us of their plans and vision for the service and changes that had taken place to ensure more person-centred care was provided. They told us they were accessible to staff and called in unannounced at any of their services.

The manager was enthusiastic and had many ideas to promote the well-being of people who used the service. They said they were well supported in their role by the provider and senior managers. The provider, director of operations and other senior management had already made several changes to improve the quality of service provision and outcomes for people since the provider had taken over the existing service in September 2016. A person who used the service told us, "The managers are very good."

All staff said morale had improved and they welcomed the changes that had been introduced by the new provider and their representatives. One staff member told us, "Changes that are happening are for the best." Another member of staff commented, "They've introduced the team leader's post and that's good." A third staff member said, "Staff morale is good." Other staff comments' included, "Differences have been made with the new management" , "We've better systems now", "Things that are changing are gradually getting better" and "We are definitely moving in the right direction." We observed the enthusiasm and motivation of staff as they supported people during the inspection.

The provider's representatives and manager were introducing more person centred care to people. They were promoting an ethos of involvement to keep people who used the service involved in their daily lives and daily decision making. One person told us, "Food is improving all the time because people at last are listening to what we say." There was evidence from observation and talking to staff that people were being encouraged to retain control in their life and be more involved in daily decision making.

The director of operations told us the management team had been strengthened to provide accountability within the home. The manager was supported by two team leaders and senior support workers. A team leader and senior support worker were responsible for a team of staff on each shift. Staff meeting minutes showed management were trying to ensure consistency across the two staff teams to provide continuity of care to people. A deputy manger's post or clinical lead post was also being introduced.

People and staff were positive about the management of the home and had respect for them. One person

told us, "I can approach managers confidently, but there is no need, because I think they do a great job." Another person said, "I think the home is well-led by the managers." One staff member commented, "Management are very approachable, there is a good rapport with staff." Another staff member said, "It's a good place to work." Other staff comments included, "[Name], the manager is very approachable", "If you raise any issue it is dealt with straight away", "I certainly feel listened to now", "I definitely feel relaxed and listened to here" and "We've a new manager who is very approachable and they get things done, which is good."

Regular meetings took place to keep staff involved and to ensure they were kept up to date with any changes in the running of the home. The manager told us they held meetings with heads of department and team leaders and registered nurses had meetings with support staff. One senior staff member commented, "We have management meetings on Tuesdays." Staff told us minutes of staff meetings were available for staff who were unable to attend. One staff member commented, "If I don't get to the staff meeting I'll always read the meeting minutes that are available." Meeting minutes were available from January 2017 and April 2017. They documented the changes that had been introduced to improve the running of the home. A standard agenda was available for the six weekly team leader meetings that were to take place with support workers starting in July 2017. The agenda showed topics to be discussed included, staff performance, training, systems, environment, health and safety, safeguarding and people's care. A staff member commented, "You can bring up what you want to discuss at meetings."

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the manager for analysis by head office.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. However, audits carried out had not identified issues we highlighted at inspection. Improvements were required to people's dining experience and staff interaction with people so staff engaged with people as they supported them. A daily environment and finance check was carried out. Monthly audits included checks on medicines management, safeguarding, care documentation, training, kitchen audits, accidents and incidents and nutrition. Three monthly audits were carried out for infection control, falls and health and safety. We were told monthly visits were carried out by the director of operations who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager to ensure they had acted upon the results of their audits.

The director of operations told us the provider planned to monitor the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were to be sent out annually to people who used the service and staff. Surveys were to be sent out in October 2017 to collect peoples' views.