The White Horse Care Trust

Whistley Dene

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24 October 2018 and was announced. At the last inspection in October 2017, the service was rated as 'requires improvement' in all key questions. We found breaches in Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, caring, responsive and well-led to at least good. At this inspection we found the required improvements had been made.

Whistley Dene 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.

Whistley Dene provides accommodation and personal care for up to five people with a learning disability, some with complex needs. At the time of our inspection five people were living in the home. The service is run by the White Horse Care Trust, within Wiltshire and Swindon.

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.

A registered manager was 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.

People were safeguarded and staff knew how to recognise the signs of abuse and how to address any concerns they had. People had risks assessed which balanced their rights to freedom as well as keeping them safe.

People's medicines were managed safely. The registered manager had signed up to a national initiative to reduce the over use of psychotropic medicines for people with learning disabilities.

Staff understood the principles of the Mental Capacity Act (2005) and how to apply its principles when supporting people. Staff were supported through regular one to one supervision and had access to regular training and personal development.

People's needs were assessed and a multi-disciplinary support plan developed to meet those needs. The service was responsive to people's changing needs and support plans were regularly reviewed.

The staff were very caring and treated people with respect and dignity. People were fully encouraged to be involved in their care and treatment and in making daily choices. The service was committed to promoting people's independence.

There were quality assurance audits in place to monitor the service and improvements were continuously sought. People and their relatives were encouraged to give feedback to facilitate change. There was a clear ethos of promoting person centred values throughout the staff team.

The provider had introduced a new management structure which was well received by staff. This had improved accountability, leadership and support for people who used the service and for the staff team.

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 safeguarded and staff knew how to recognise abuse and how to report any concerns.

Risks to people were managed and assessments were in place to manage the risk and keep people safe.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care planned to ensure it met their needs.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received regular support through one to one supervision.

Staff had been trained in the Mental Capacity Act (2005) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff encouraged people to be fully involved in their care and express their wishes and choices.

The service fully promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

The service was responsive to people's changing needs and care plans were updated to reflect this.

People were supported to understand how to raise concerns by a variety of pictorial and media methods.

People's diverse needs were respected.

Is the service well-led?

Good

The service was well-led.

The service has systems in place to monitor the quality of service.

The service looked for ways to continuously improve.

The new management structure was well received and was making positive improvements to the service.

Whistley Dene

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 24 October 2018 and was announced. We gave the service short notice of the inspection visit because the people living in the home can become unsettled by the presence of an unannounced visitor. The inspection was carried out by one inspector.

Before the inspection we reviewed the information, we held about the service and the service provider. This included statutory notifications sent to us by the registered manager and their most recent provider information return form (PIR). Notifications are information about specific important events the service is legally required to send to us. A PIR is a document which provides information about the service such as what they do well and what improvements they plan to make.

We spoke with two relatives, three care staff, the registered manager, the team leader and the area care manager. During the inspection we reviewed three people's care plans and daily records. We observed the care and support people received. We reviewed records relating to the management of the service, including policies, procedures and staff personnel files. We looked at accident and incident reporting and quality assurance audits. We contacted three professionals without any responses to our request for feedback about the service.

Good

Is the service safe?

Our findings

At our last inspection in October 2017 we found that the provider was in breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not always protected from the risk of potential harm. Risks to people's personal safety had not always been assessed and plans were not in place to minimise these risks. During this inspection we found that the provider had made significant improvements in this area.

Care plans contained risk assessments for keeping people safe whilst also maximising their independence when in their home and when accessing the community. People had a 'missing persons' sheet detailing a photograph, their physical appearance and communication method. People had personal emergency evacuation plans (PEEP)'s in place with specific emergency evacuation procedures for both day and night. There was a 'grab file' to take when evacuating, which contained PEEPs, the homes fire procedures, continuity plan and up to date critical information about people using the service.

Risks assessments were incorporated into many areas of people's support plans including for example, 'everyday tasks', 'living safely' and 'choice and control'. Personal goals were identified and changes made to support plans were developed from details identified from the risk assessments.

We saw a comprehensive risk assessment around supporting one person to use the bath or shower. The initial assessment included assessing the person's abilities, level of support required and which equipment would be used. A hazard identified was the risk of scalding. Existing controls to minimise the risks were among others, thermostatic valves fitted, recordings of water temperatures and the checking and calibration of thermometers. A further hazard identified was the risk of drowning. Controls to minimise these risks were the person was never to be left alone and the staff were trained in emergency procedures. Both risks were assessed as being low.

Another person had a risk assessment for choking. The speech and language therapist (SALT) had produced guidance for staff to follow regarding the types and textures of appropriate foods and fluids. This person preferred sandwiches which were easier to swallow and had also been losing weight. Following their SALT assessment and guidance to increase appetite and make fortified meals, we observed the person's weight had increased, stabilised and they were now enjoying a wider variety of foods.

The provider had made improvements to their accidents and incident monitoring and reflected on them as a means of improving safety for people. One person, who enjoyed sitting outdoors, had developed sunburn on their face. The staff member reported this in the communication book and completed a body map. On-going actions from this incident included ensuring sun cream was applied to exposed skin 30 minutes prior to going outside and other appropriate protection such as a sun hat.

The same person also had a risk assessment and actions implemented around drinking hot drinks independently. This was introduced in response to a safeguarding incident where the person had spilt a hot drink which had caused their skin to blister. A 'protection passport' was introduced. The control measures

put in place were for staff to ensure that hot drinks were of a suitable temperature, that the person was wearing a clothes protector and the cup was not over full. This enabled the person to drink hot liquids safely and independently.

The registered manager had a 'tracker' in place to monitor all accidents and incidents which helped them to identify themes and trends. This meant the provider had learned lessons when things went wrong and had taken appropriate long term actions to prevent re-occurrences.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. One staff member told us, "If something is worrying me or I am concerned about some treatment the first person I would go to is [the registered manager]." Another member of staff told us, "If I've noticed a mark or a change in behaviour, I would report it to the manager and she gets in contact with safeguarding." Staff had received training in safeguarding practices and procedures and we saw the local authority safeguarding flowchart giving guidance to staff, on the wall of the office.

Staff were also knowledgeable about whistleblowing. One staff member told us, "I would go to the CQC." Whistleblowing procedures ensure that the staff member is protected from reprisals when they raise concerns of misconduct they have witnessed at work.

Staff were recruited safely. Pre-employment checks were completed. These included references, identity checks and DBS. The Disclosure and Barring Service (DBS) check allows employers to make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups of people.

The registered manager told us they had access to agency staff if they were needed. A member of the management staff supported the service if there was staff sickness at short notice. However, this sometimes meant it impacted on people's activities. One member of staff told us they felt they were "Short staffed at the moment, but this place has changed for the better."

The registered manager had signed up to a national project to stop the over use of psychotropic medicines for people with a learning disability. Each person had a risk assessment and medicines review in line with the projects recommendations. Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy. They are sometimes used for managing behaviours which are seen as challenging. People with a learning disability are more likely to be given these medicines than other people. There are other ways of helping people so that they need less medicine, however they are appropriate for some people.

Medicines were managed, administered and stored safely. The provider had a medicines policy and comprehensive 'as required' (PRN) protocols for people's individual medicines, in place. There was guidance in place for the topical application of creams including a body map. The service also had a protocol around the administration of homely remedies. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used in a care home for the short-term management of minor, self-limiting conditions, e.g. headache, cold symptoms, and mild occasional pain.

People had a personalised medicines profile which detailed how they preferred to take their medicines. Staff told us they had observed competency assessments and training in medicines administration. This included how to complete a medicines administration record (MAR) and recording when a medicine had been refused. A pharmacist had trained staff in the management of specialised medicines for the treatment of

cancer. These medicines were stored separately. Stock checks were completed daily and a full medicines audit was carried out weekly.

People were protected from the risks of infection. Staff told us they had training in infection control practices and we observed hand gels, paper towels and personal protective equipment in place. The home was clean and tidy with no unpleasant odours. People were supported to undertake safe hygiene practices in the kitchen for example, being reminded about hand washing.

Good

Is the service effective?

Our findings

At the last inspection we found that where people's capacity to consent had been assessed, assessments had not been reviewed since the last inspection in August 2015. At this inspection we found that significant improvements in this area had been made, assessments had been reviewed and were up to date.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. For example, one person was admitted to hospital to receive treatment for cancer. The person's hospital bed was fitted with bedrails, which the registered manager did not feel was required and was an un-necessary and potentially unlawful restriction. The registered manager ensured the person's independent mental capacity advocate (IMCA) was informed and gained advice and guidance on how to proceed with this restriction according to the persons deprivation of liberty safeguards conditions.

Mental capacity assessments had been robustly completed along with their corresponding best interest decisions. The provider had made appropriate applications to the local authority for DoLS and had a 'tracker' system to monitor their progress including screening and when an authorisation was due for renewal. The staff we spoke with were knowledgeable about the Act and how to apply this in their work with people. This meant the provider was fully compliant in meeting the lawful requirements of the Mental Capacity Act (2005).

At our last inspection we found that people were assisted by staff who had not always had the opportunity to remain up to date with core training required by the provider. At this inspection we found improvements had been made.

We spoke with the training manager for the White Horse Care Trust who told us they had developed a new training platform which included e-learning as well as face to face training. It pulled all the systems for training and monitoring of training needs into one set of data and was in the early stages of implementation. The new system enabled managers to track which training for which staff member had been completed, was due or was out of date. It also showed when staff had read Trust policies. The training manager told us, "[The registered manager] sent me a list of training which was out of date and we have sent people [for

training] when we could" and "She is very proactive in getting training underway, Whistley Dene is one of the first homes for the new platform."

We looked at the annual training matrix. The annual training programme for mandatory training was now booked for the next full year January 2019 to January 2020. Mandatory training included among others, safeguarding, medicines competency and person-centred working. For 2018, staff were being released regularly to attend training in among others, dementia, autism and specialist training with a nationally recognised training provider of managing behaviour that challenged. Some staff at Whistley Dene were being trained as trainers for the staff group in moving and handling. The training manager told us, "It makes sense to have experts in the home, they can train staff, it has been prioritised at Whistley Dene."

The staff we spoke with told us that their training had been 'behind' but was now coming back. One staff member said, "I am due to do my safeguarding training next week, there are a lot of training workbooks and face to face, I like the practical training. I feel I have appropriate training to date." The team leader told us "I feel I have a lot of skills. I am really big on training, for all of us. It is key."

New starters received a thorough induction. They completed White Horse Care Trust workbooks and a resource pack for each standard following the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme. Staff were observed prior to being signed off to work alone which formed part of their probationary period.

Improvements had been made to supervision. Staff had access to regular one to one support in the form of formal supervision and regular 'job chats'. The staff we spoke with were complimentary about the registered manager and the team leader and felt well supported. One staff member told us, "100% feel supported, it's always nice to have a manager who you can talk to. We have one supervision formally, every four months and lots of informal. Any problem and [the registered manager] will fit me in." Staff could discuss their training needs, any concerns or issues and development opportunities. The team leader told us she had requested to undertake her Level 5 national vocational qualification in leadership for health and social care management, and the provider was supporting her with this.

People's needs were assessed by a multi-disciplinary of professionals to ensure their needs were met appropriately. Individual needs were assessed and reviewed annually or when there were any changes. Support plans were person centred and included areas such as 'things important to me', life histories as well as comprehensive assessments of physical and emotional needs.

Each person had a one-page profile in their support plan. A one-page profile is a simple summary of what is important to someone and how they want to be supported. Care plans contained people's preferences and choices. Staff told us "People are able to make choices and decisions about what they like. We give people options of what they might like to wear, we hold up outfits and help them to make a decision."

People were involved in planning their meals and had support from staff to shop for groceries. One staff member told us "We ask the residents what they would like to eat." People were able to have alternatives and make changes if they wished. We observed that people had access to sufficient food and drink and people were offered drinks frequently.

The staff we spoke with told us they worked with professionals such as learning disabilities nurses, physiotherapists and occupational therapists to deliver effective care to meet people's needs. People had

access to medical professionals when this was required. For example, one person was supported to attend hospital appointments for specialist treatment and staff stayed with the person in hospital to provide continuity of care.

There were fully recorded descriptions of visits and telephone discussions with community health colleagues with outcomes and actions of appointments, for example advice from the GP, new medicines and if a further appointment was to be made. We saw that people had received their Cardiff health checks annually. This was a comprehensive physical and mental health check specifically developed for people with learning disabilities. Each person had a diary of health appointments attended and forthcoming.

People had access to preventative healthcare such as receiving the flu jab and attendance at the asthma clinic. Where appropriate individuals had been supported with their representatives and GP's to discuss a Treatment Escalation Plan (TEP). The registered manager told us, "We have really good open lines of communication with the community team and have link meetings regularly."

Whistley Dene is adapted to meet the individual needs of the people living there. There were large garden areas all around the bungalow which was situated in a quiet area of countryside. People had access to the outside space. People had personalised their rooms according to their interests and preferences. One person who had a visual impairment, had recently moved rooms so that they could sit quietly and in privacy with the sun coming through their window onto their face, which they enjoyed. The environment was homely and comfortable.

Good

Is the service caring?

Our findings

Relatives we spoke with were complimentary about the standard of care and support their loved one received. One relative told us, "[my relative] is very well cared for. The staff are so kind, very kind and caring. Nothing is too much trouble." Another told us, "[my relative] is very happy, I am very happy." People who lived at the service were not able to verbally tell us how they felt, however the observations we made were positive. People were calm and comfortable in the presence of staff.

We observed very gentle and kind interactions with one person who was not feeling well. The staff member needed to take their temperature, they asked the person's permission first and then proceeded in a calm manner explaining all the time what they were doing and how long it would take to complete. This person was also gently encouraged to try to explain where their pain was when the health practitioner visited to assess them. The staff member knew the person well and was able to interpret their behaviours to the health practitioner. Following their assessment, the person was in distress but was given lots of gentle reassurance, explaining that they were going to have a tablet soon for the pain.

Another person with a visual impairment was spoken to gently. Staff used light touch to alert the person of their presence. They were given steady, un-rushed instructions when taking their medicines, having explanations of what the medicines were and how many. They were encouraged to take them and drink plenty of water. The staff member proceeded to ensure they were comfortable and checked that they were happy. This person did not use verbal communication and the staff member told us, "When [person] hums gently we think this indicates he is relaxed and happy, [they] also uses facial expression to communicate and grinds his teeth when not happy."

We heard from one relative who told us they were always kept informed of their family member's daily life and current health treatment. In addition, the registered manager also contacted them with positive everyday information such as what kind of day their family member had and what they had been doing. This was very much appreciated by the relative who told us they felt more involved in their family members daily life. We saw records which confirmed regular contact made with family members regarding treatment, appointments and outcomes. A staff member told us, "This is their home and we will support them how they want us to."

People had hospital passports in place should they need to be admitted to hospital. These contained important information regarding their communication methods, behaviours and what they mean, their likes and dislikes and their abilities. This meant that hospital staff would have a better understanding of their care needs which helped to maintain their dignity and independence.

Staff provided support which was dignified and respectful. The staff we spoke with understood the importance of maintaining people's confidentiality and had a clear understanding of how to apply the principles of privacy and dignity when supporting people. These included, closing doors when people were in bathrooms, closing their curtains when providing personal care as well as protecting their confidentiality with their personal information.

Positive changes had been made to one person's environment to improve their day to day experience. This person had a visual impairment and had been asked (in conjunction with their family) if they would like to change their bedroom to enable them to have more sun and warmth in their room. This person preferred to sit in their room or in the sun room alone, as they found noise and too many people distressing. They were supported to move to a room where the sun shines all morning and they enjoyed sitting with the warmth and light on their face. They spent the afternoons in the sun room with a blanket over their knees for comfort.

Care plans and daily records we observed were written using respectful language. Staff told us they enjoyed supporting people at Whistley Dene. One staff member told us, "You build up a tremendously tight bond with clients. Like to feel like you're making a difference." Another told us, "I love [the people] to pieces, it's nice here because you get to know them on a one to one basis." Another staff member was passionate about promoting people's human rights saying, "It's about people rights and about them getting their rights that they should have, safely."

Good

Is the service responsive?

Our findings

At our last inspection in October 2017 we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans that required clarifying had not been reviewed and amended to reflect the person's care needs. During this inspection we found that the provider had made significant improvements in this area.

People's changing needs were responded to and action taken to provide the right care and support. For example, we saw that following a psychiatric assessment one person had their medicines reviewed. A medicine they were prescribed was stopped by a clinician which resulted in a reduction in their mobility. The registered manager responded to these changes and called the clinician. This intervention resulted in the medicine being started again which improved their mobility. Following an additional review the person was provided with a specialist chair and additional equipment. This meant the person was able to independently reach for their pencils and colouring books, picture books and items of interest and had them all close at hand.

At the time of the inspection one person was experiencing pain and was distressed. We saw that staff were observant in their support, recognising when people were in pain or when their behaviour was changing. The staff immediately contacted the GP to request a home visit. A health practitioner arrived and thoroughly assessed the person and found that they had an infection and treatment was started straight away.

The service was supporting people who had a diagnosis of dementia and were receiving support under the dementia care pathway. They had been assessed using a dementia intervention checklist to ensure all relevant services were involved. Monitoring of physical, mental and emotional behaviours were recorded and guidance to staff on when to request further support. For example, if the person's weight fell below a certain level or their mobility declined.

One person was receiving specialist hospital treatment as an out-patient but also at times for in-patient care. The service developed a rota of staff cover to accompany them to assist with communication and to ensure the person had a familiar person with them in an unfamiliar environment. This person's health action plan for hospital staff detailed the support they required such as personal care and mobility and how they liked to take their medicines. In addition, it detailed their preferences and what their behaviours meant. For example, 'these are the drinks I like to drink, I need to stay well and hydrated, if I don't like them I will push them away.'

One key area of new training for staff was the NHS national early warning score monitoring (NEWS). The team leader told us this was an accurate way to detect when a person was becoming ill or potentially developing sepsis as it identified subtle changes in people's health. For example, for one person who is not able to verbally express pain, this system identified that key triggers such as holding their arms and grinding their teeth, indicated pain. The team leader told us that staff were skilled at recognising when someone's behaviour was changing and that it potentially could indicate the person was experiencing pain.

The service was fully compliant with The Accessible Information Standard. This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The different communication methods used were, pictorial diagrams, PECS systems, Makaton and signs and gestures according to the person's preferred method of communication. PECS is a picture exchange communication system developed for people with learning disabilities and Makaton is a form of sign language.

People were able to participate in different social activities within the home and in the community. People were supported to access their local community to attend day services and clubs. We observed that people were asked what they would like to do and one person chose to colour and draw with their pencils and another person looked at magazines and picture books. Where people were able, they were encouraged to join in with everyday household tasks. These included making their bed, helping with the laundry and preparing simple meals. The team leader told us they hoped to make more use of the large outdoor space and develop a vegetable garden for people to grow and harvest some of their own food.

The service had a complaints policy and procedure in place. People were supported to understand the complaints process by watching a DVD and for people whose communication method was preferred, there were pictorial and (PECS) versions. Relatives we spoke with told us they had not needed to complain and were very happy with the care and treatment of their family member. There were no current complaints being investigated.

At the time of our inspection no-one was receiving end of life palliative care. However, each person had a care plan which recorded their thoughts and plans for end of life care. The plans contained recorded details of the person's life history, important memories and important relationships. Specific questions were asked, for example who is important to me? what decisions can I make? What does it mean to die? and what I would like to happen to my possessions. People had recorded detailed preferences for their funeral arrangements. For example, their name in the book of remembrance and certain hymns.

Good

Is the service well-led?

Our findings

At our last inspection in October 2017 we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Quality audits and monitoring had not been completed to ensure improvements were identified and acted upon. During this inspection we found that the provider had made improvements in this area.

There was 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.

There was a clear management structure in place, which had recently been revised to make the running of the service more effective. The service now had a registered manager who was dual registered for two services and a team leader to provide leadership when the registered manager was not present. A staff member told us, "This manager is making improvements and listening to staff, she is much more about encouraging them to do things for themselves and is very keen to improve the culture."

There were systems in place to monitor the quality of care being provided with several layers of checks and accountability. People's keyworkers were responsible for auditing care and support plans which are audited by the registered manager. The registered manager undertook monthly audits which were reviewed by the area care managers and upwards to the care operations managers. If anything was identified throughout these checks the issues were added to the 'corrective preventative log' (CPL). This was how the senior management structure monitored accidents, incidents and areas for improvements identified in audits. These included immediate actions to rectify any concerns found, preventative measures and recording of lessons learned and actions taken.

The service had a health and safety lead. The environment and all equipment used in the home, for example hoists and slings were audited monthly. It had been identified that improvements were required in the bathrooms and the service had to work alongside their landlord to ensure maintenance and repairs were made. Audits detailed who was responsible for the action, when it was to be completed and the status of the issue. There were plans in place to introduce health action plans and kitchen records to the auditing process.

The care operations manager told us that she can see easily from the CPL how managers were performing and where they needed to spend their time. "Registered managers are feeling more supported and our time is managed more effectively."

The service sought feedback from people, families and staff. They had developed a pictorial format of feedback in conjunction with a large local hospital to gain people's experience of using hospital in-patient services. They requested annual feedback from families and had regular staff meetings. Relatives we spoke with were very complimentary about the care and treatment their family members received. One relative

told us, "If he was the Prince of Wales he couldn't be treated any better" and "They do as much as they possibly can, its 100%."

The provider had recognised that changes were required to some of their systems to ensure the services were moving forward and learning when things did not meet expectations. For example, a re-structure of the management tier had resulted in new leadership roles to share responsibilities in each service and provide opportunities for growth. This meant targets from audits were looked at more frequently making them more responsive. The care operations manager told us, "We look at things from an accountability perspective, if you can't meet a deadline let's talk about it, for example around supervisions, what have you done today to make it good?"

The staff we spoke with spoke highly of the new registered manager and the support they now received from the management team. One staff member said, "Since [the registered manager] things have improved greatly, far more structure. Always on the end of the phone, staff know that and that is really important for staff." Another staff member told us, "I think this whole place is running better, noticed the change straight away, [the registered manager] knows how to run a home, great at looking after the staff and the residents like her, it's going back to having a structure."

The team leader was very positive about the new role and how it was improving the support for staff as well as the running of the service. They told us, "It's bringing in more organisation, it's going really well and [the staff] are really accepting, really keen on having the extra support. They are quite happy that I am here and the new structure. My ideas are well received and there is a lot of good support."

The service worked closely with their local community to make use of resources and share good practice. For example, for one person using day services, they arranged specific times to re-introduce them to other people and staff after a long period of not attending. The registered manager was part of the registered managers network as well as the White Horse Care Trusts managers forum. They worked with local authority commissioners and the adult social care quality assurance team.