Precious Homes Support Limited

Chandos Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 August 2018 and was announced. The provider was given 24 hours' notice to ensure people would be available to talk to us during the inspection. The previous inspection was completed in August 2017 and had found breaches of regulations relating to person centred care, safe care and treatment, staffing and governance. The service had taken effective action and was now fully meeting the regulations.

Chandos Road is a 'care home' for people with acquired brain injuries, the service only supports men. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chandos Road accommodates seven people in one adapted building. Each person has their own bedroom with en-suite bathroom facilities and free access to shared living, kitchen and dining spaces as well as a large garden.

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.

The registered manager provided excellent leadership to the home, demonstrating person-centred values in his approach to people, relatives and staff. They had taken on board feedback and worked with the provider and external agencies to achieve significant improvements in the quality of people's experience of care. They took a flexible approach to engagement which ensured people, relatives and staff were involved in developing and improving the service. There were effective audit and quality assurance systems in place which ensured the safety of people living in the home.

People felt safe and staff were knowledgeable about how to safeguard people from abuse and avoidable harm. The service took a positive approach to risk taking, ensuring people were facilitated to take risks where they had capacity to do so. Staff had clear, up to date information about how to mitigate risks people faced. There were enough staff who had been recruited in a way that ensured they were suitable to work in a care setting. People were supported to take their medicines and systems ensured this was managed safely. The home was clean and free from malodour. When incidents occurred the service completed thorough, transparent investigations and took action to ensure the risk of recurrence was mitigated.

People's needs were assessed in a holistic and person centred way. This led to care plans which focussed on people's goals and aspirations. Staff were well supported by the registered manager and received the training they needed to perform their roles. People were involved in planning and preparing meals and records showed people were supported to maintain nutritious and balanced diets. Staff worked with other professionals and healthcare services to ensure people received the support they needed and had their healthcare needs met. The home environment reflected the preferences of people living in the home. Staff

were working within the principles of the Mental Capacity Act 2005 and there was clear information about how to support people to make their own decisions.

People told us the staff were friendly and caring. Staff told us they had time to develop meaningful relationships with people. Staff spoke about the people they supported with kindness and respect. The service considered people's religious beliefs and cultural background and supported people to attend places of worship and maintain their cultural identity. The service provided an environment where people could disclose their sexual and gender identity.

People met with their keyworkers each week where their care was reviewed and updated as needed. People were supported with a range of activities of their choosing. People knew how to make complaints and complaints were responded to appropriately with changes made to how the service operated when needed. There were systems in place to ensure people received appropriate support if they reached the last stages of their life.

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 told us they felt safe and staff understood how to protect people from avoidable harm and abuse.

People were supported to manage the risks they faced; the service took a positive approach to risk taking.

There were enough staff on duty who were suitable to work in the service.

People were supported to take medicines and systems ensured this was managed safely.

The service was clean and free from malodour.

The service responded positively to incidents and ensured lessons were learnt.

Is the service effective?

Good

The service was effective. Staff received the training and support they needed to perform their roles.

People's needs were assessed in a holistic and person centred way which ensured their care was planned to support them to achieve their goals and aspirations.

People were supported to eat a range of nutritious and balanced meals of their choosing.

The service worked with other professionals and healthcare services to ensure people's needs were met.

The building and gardens were suitable for people and had been personalised to people's tastes.

The service was working within the principles of the Mental Capacity Act 2005 and people were supported to make their own decisions about their care.

Is the service caring?

Good

The service was caring. People had developed trusting relationships with staff who provided appropriate emotional support to them.

People's religious beliefs and cultural backgrounds were respected and supported.

The service ensured they provided a safe environment where people could disclose their sexual and gender identity.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive. People were involved in reviewing and updating their care plans to ensure they received personalised care.

People were supported to attend a wide range of activities of their choosing.

People knew how to make complaints. Complaints were responded to appropriately with changes made to the service where needed.

There were systems in place to ensure people would receive appropriate end of life care if this was needed.

Is the service well-led?

Good

The service was well led. The registered manager provided exceptional leadership and demonstrated a values based approach to managing the service.

There were effective systems in place to monitor and continuously improve the quality of people's experience of care.

The registered manager ensured that people and their relatives were involved in developing the service.

The service had achieved accredited provider status with Headway the brain injury association. This ensured the service was up to date with developments in supporting people with acquired brain injury.

The provider had effective systems in place to develop managers and engage support workers.

Chandos Road

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.

The inspection was carried out on 1 and 2 August 2018 by one inspector and one assistant inspector. The provider was given 24 hours notice of the inspection as the service provides support to people who are often out during the day and we needed to be sure people would be in during the inspection. The service was last inspected on 3 and 4 August 2017.

Before the inspection we reviewed information we already held about the service from notifications they had submitted to us. Notifications are information about events providers are required by law to tell us about.

We had requested a provider information return, but the deadline for submitting the information had not passed by the time we inspected. The registered manager was completing the information as required and we received it soon after the site visit. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We had received feedback from the local authority monitoring and safeguarding teams in the year since the last inspection.

During the inspection we spoke with four people who lived in the home and four members of staff including the registered manager, the team leader and two support workers. We reviewed three people's care records including care plans, risk assessments and records of care. We reviewed five staff files including recruitment, supervision, and training records. We also reviewed various meeting minutes, records, and documents relevant to the management of the service.

Good

Is the service safe?

Our findings

In August 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people had not been appropriately identified or mitigated. The provider had fully met the warning notice we issued and there were now effective systems in place to identify and mitigate risks.

People told us they were supported to make their own decisions about the risks they took in their day to day lives. For example, one person told us they were reminded of the risks of a particular behaviour but were not stopped from doing it, as this was their choice. Records showed risks faced by people were clearly identified, with assessments considering each person's ability to understand and evaluate the risks themselves. This assessment led to detailed information for staff about how to support people to mitigate risks. Where people's risks changed we saw risk assessments were amended and reviewed to ensure they stayed up to date. For example, one person had developed difficulties with their swallowing and records showed the provider had sought professional support which had been incorporated into detailed guidance for staff.

Staff told us they received clear information about how to mitigate risks and knew how to respond to changes. One staff member told us they would report any concerns that risk assessments needed updating to the registered manager. We saw risk assessments were discussed in weekly keyworker meetings and if they were considered to be 'not working' they were amended and re-evaluated. Where people could behave in ways that put them or others at risk of harm there were clear measures in place to identify early signs and mitigate the risk of escalation. At the last inspection we were concerned that risk assessments relied on a single member of staff who could speak the same languages as people living in the home to mitigate risks caused by communication breakdowns. The provider had recruited additional staff who spoke these languages to ensure the risk assessments could be followed at all times.

The provider used technology to ensure measures in place to mitigate risks were not overly restrictive. For example, one person had a tracking device which allowed staff to monitor their location from a distance. This was in place to mitigate the risk of increasing the persons agitation as it was recognised it was safer to allow them to be alone in the community than restrict their movements. The tracking device meant staff could give the person time to calm down and locate them easily when they were ready to be supported again.

In August 2017 we made a recommendation that the service seek and follow best practice guidance around recruitment practice. This was because it had not been clear how recruitment decisions had been made, and records were not available in the service. The provider had followed this recommendation and the registered manager told us the provider had made significant investment in the recruitment practice across the different services. Records now clearly showed applicants were interviewed and assessed against set criteria which were specific to the service. For example, staff were asked about their understanding of brain injury and its impact on people's experiences as well as their knowledge of the provider and other aspects of care. The provider collected employment references or where people did not have an employment history appropriate character references were obtained. The provider carried out appropriate checks on applicant's

criminal records and right to work to ensure they were suitable to work in a care setting.

People told us there were enough staff to meet their needs. Staff told us they thought there were enough staff on duty. One member of staff said, "We do not have to rush. There's plenty of time, we can support people with their care and get lots of time to support them to do activities and go in the community. We have plenty of time to get to know people." The provider had a pool of bank staff who were used to cover planned and unplanned absences. In addition, the registered manager told us there were named agency staff who could cover absences in emergency situations. The use of agency staff was minimised as the provider recognised unfamiliar staff had a negative impact on people's experience of support.

People told us they felt safe living in the home. One person said, "Oh yes, I feel safe here. Everything I need is done for me." Staff were knowledgeable about the different types of abuse people might be vulnerable to and were confident in describing the actions they would take if they suspected abuse. One member of staff said, "I'd make sure the person was OK, then I'd tell the registered manager. I'd fill in an incident form." Staff knew how to 'blow the whistle' if they were concerned that the actions of other staff or managers were causing harm to people. One member of staff said, "That's whistleblowing, they explained that in the training. We have the number on our ID badges so we can call them if we needed to."

Records showed the registered manager followed the provider's policy regarding safeguarding and raised alerts with the local safeguarding authority following allegations of abuse and incidents. We saw they completed robust investigations when these were delegated to them by the safeguarding authority and ensured people were protected from abuse and avoidable harm. Incidents and safeguarding concerns were discussed in individual staff supervisions and in staff meetings to ensure staff were aware of the processes and what actions had been taken to ensure people were safe from harm. Where the service held money on behalf of people there were robust systems in place to ensure they were not financially abused. We checked the records of money held and found they were correct.

People told us staff supported them to take their medicines. One person said, "They help me with my tablets." People had individual medicines care plans which detailed the medicines they were taking, the reasons why and any adverse reactions of which staff needed to be aware. Where people were prescribed medicines on an 'as needed' basis there were guidelines in place which advised staff when to offer and administer these medicines.

Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

Records showed people were supported to take their medicines as prescribed. The team leader completed weekly audits and the registered manager completed monthly checks to ensure medicines were managed in a safe way. Staff confirmed they did not administer medicines until they had been trained and assessed as competent.

Staff wore appropriate personal protective equipment to ensure the risks of infection were mitigated. There were signs on display to remind staff of appropriate processes to follow to ensure safe hygiene practices were followed. Staff meetings records showed staff were reminded regularly of safe infection control practice and there were regular checks of the cleanliness of the service.

Incident records showed staff took detailed notes of incidents which were reviewed by the registered manager who took appropriate action to ensure the risk of recurrence was mitigated. Where necessary care

plans and risk assessments were updated and referrals to external professionals were made. For example, following a fall where a person hit their head an interim care plan and monitoring system was implemented to ensure the person was closely monitored for concussion. This was communicated to staff via the internal communication logs and handovers and records showed the checks were completed as required. The home communicated with people's relatives and other professionals involved in their care in a timely way to ensure they were aware of any incidents and the actions taken.

Good

Is the service effective?

Our findings

In August 2017 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received the training they needed to perform their roles. The provider had taken effective action to address these concerns and staff now received the training they needed to perform their roles.

Staff completed the core training required by the provider which ensured they had the fundamental skills required to be a support worker. Staff told us they completed an induction to the company and this included a mix of classroom and online training. In addition, the service had developed a specific suite of learning to ensure staff could meet the specific needs of the people they supported. This included training in acquired brain injury, responding to behaviours which could challenge, diabetes, epilepsy and communications.

People told us they thought staff were good at their jobs and staff told us they found the training useful. One member of staff said, "I had a lot of training, lots of it was online. It was really useful. I did a training about brain injury as well. That helped me understand people living here."

Staff received regular supervisions from the registered manager. Records showed supervisions were used to support the development and performance of staff, with recognition for achievements and support where performance needed to be improved. We saw staff members were given goals and their progress towards them was monitored by the registered manager. Staff told us they found these supervision meetings supportive. One member of staff said, "I find it helps if we can talk it through as well as read it in the training. [Registered manager] will take the time to do that with me in my supervision. It makes me better at my job."

People told us they had met with the manager and had conversations about their care needs before moving to the home. Records showed the registered manager completed a comprehensive needs assessment before people moved to the home. The assessment considered people's strengths and needs as well as the support they would need to maintain their social and cultural connections. The assessments considered all aspects of daily living and ensured the resulting care plan contained a mix of the support people needed for the things they needed to do, and the support they wanted to achieve their aspirations. For example, the level of support with personal and domestic tasks was included and given equal value to the importance of finding volunteering and work opportunities to increase the person's self-esteem.

One person said, "They cook the food and serve it too." We saw care plans contained detailed information about people's dietary needs and preferences. This included where people followed particular diets due to health reasons or religious beliefs. People wrote their individual menus on a fortnightly basis and records of care showed people were supported to eat a range of balanced and nutritious meals. House meeting records showed people talked about the menu and the shopping and were involved in writing the shopping lists. Where people were being supported to develop their independence skills they were supported to prepare meals of their choosing. One person living in the home had worked as a chef prior to their injury and it was clear they were being supported to increase their levels of confidence and involvement in meal

preparation.

Records showed staff supported people to access various services to ensure they received effective care and treatment. We saw information about people's behaviour and presentation was shared appropriately with social services and other organisations involved in providing support to people. Following incidents or changes in people's needs there was clear communication to ensure all parties knew what support was planned and people's level of engagement with it.

People living in the home told us staff supported them to access healthcare services when they needed. One person said, "They'll take me to the doctor if I need it." People had health specific care plans in place and staff maintained clear and detailed records of health appointments. Any changes to people's care needs as a result of the advice of healthcare professionals was incorporated into their care plans immediately. For example, we saw one person was seen by medical professionals and referred to physiotherapy following a change in their condition. People were encouraged to be involved in decisions about their healthcare services as far as they were able. For example, some people were able to identify they needed to visit a healthcare professional, and would ask staff to arrange appointments, while others relied on staff to identify the need but would choose the time of appointments.

People who lived in the home had created artwork which was on display throughout the home. There were photos of people from holidays and activities on display in communal areas of the home. People's bedroom doors were personalised with items of their choosing on display. House meeting and keyworker notes shows people were involved in choosing the decoration and furnishing of their bedrooms. The home had a large garden with a number of raised flower beds as well as a vegetable patch. Some of the plants had been donated by a relative following discussions with their family member who wanted to be more involved with the gardening. Some people's care plans included information about being involved in gardening and during the inspection one person was actively involved in taking care of the garden. The building itself was a terraced house which had been adapted to ensure it was suitable for people's physical needs. The service used clear visual timetables and low distraction environments where this was needed to facilitate people's support.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans contained detailed information about people's ability to make both day to day and complex decisions. Their ability was assessed for each type of decision in line with best practice guidance. There was clear information about the facilitation required to ensure people were able to make their own decisions, including presenting the information in visual formats, ensuring it was presented in their first language and avoiding asking them to make decisions at certain times of day.

Where people were assessed as lacking capacity to make decisions there was clear guidance about how to

ensure they were still involved in the best interests decision making process. Each aspect of every care plan included information about how to ensure people were involved in making decisions about their care. For example, in one person's plan it was detailed that they would make the choice of activity but staff structured the activity as they did not have capacity to sequence it themselves.

Staff demonstrated they understood how the MCA applied to the people they worked with. One staff member explained, "[Person] cannot make all the decisions but he still has choices. For example, with money he can choose what to buy day to day, but wouldn't be able to deal with things like care contributions." Another care worker said, "We always respect their choices."

Some people were subject to DoLS and there was clear information about this in their files. Where people had appointed decision makers for aspects of their care this was clearly recorded and records showed the service was in regular contact with them to discuss aspects of people's care. People told us they could go out when they wished, and they did not feel restricted. One person said, "I do what I want. I make all my own choices." To ensure some people's safety there were locks on the front door, and records showed those people who were not subject to restrictions were offered keys and some people used these.

Good

Is the service caring?

Our findings

People told us the staff were "friendly" and "caring." They told us that staff would support them if they were upset and they felt secure they would be given emotional support if they needed. One person said, "If you're upset the staff talk to you." Care plans contained detailed information about how people expressed their emotions, and the support staff should provide if people needed emotional support. A care worker said, "There's detail in the care plan. I will still ask what's wrong if I can see he is upset, but I think he finds it helpful that I'm likely to know what it might be about."

The importance of people's relationships and maintaining contact with family and their local community was clearly captured in care plans. People confirmed they were supported to stay in touch with family members. Regular phone calls and visits were included in people's daily schedules and care plans had been updated to include clear information about the different relationships people had. The registered manager recognised the importance of people's family roles as part of their identity. They said, "[Person's] behaviour has improved a lot recently. I think it's partly because he is now seeing his family more often. It reminds him who he is."

None of the people living in the home had disclosed if they identified as gay, bisexual or transgender. The service endeavoured to create an atmosphere that would encourage people to disclose this information if they wished. The provider's equality and diversity policy included clear reference to ensuring people were not disadvantaged or subject to direct or indirect discrimination based on their sexual orientation. A care worker said, "We don't discriminate. It's their life and it's our job to support them to live it how they want."

Staff supported people to maintain their cultural identity. The things people needed to maintain their identity were included in care plans. For example, one person's care plan stated, "Prior to [religious festival] my key worker will discuss the idea of presents and help me create a budget for it. I will decide who to give presents. Staff needs to support me to buy the presents and pack them and help me write people's name on it. I like to celebrate [cultural event] by going to the pub for a drink."

Regular attendance at places of worship were included in people's activity schedules and records showed people attended as they wished. There were photographs on display which showed people celebrating key cultural and religious festivals together.

Staff demonstrated they understood the importance of people's cultural identity to their wellbeing. One care worker explained, "I share a cultural background with [person]. It's important to him to be able to talk about things related to our culture and it can help him calm down if he's getting stressed about something."

People told us staff respected their privacy and treated them with dignity. One person said, "They respect who I am." Care files included detailed directions about how to ensure people's dignity was maintained when they were being helped with intimate care tasks. Throughout the inspection staff were polite in their interactions with people and always knocked on people's doors and waited for a response before entering. Staff spoke about the people they supported respectfully. Staff spoke about the values and attributes of

people's characters. For example, one care worker said, "[Person] is such a gentleman. Always very polite and when we go to the shops he'll get things from the shelves that I can't reach."

Good

Is the service responsive?

Our findings

In August 2017 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans had not been kept up to date, and the service was not always able to support people in line with their care plans. The service was now fully meeting this regulation.

People told us they received the support and care they wanted. One person said, "I do what I like." Care plans were highly detailed and personalised with clear guidance for staff about how to provide support to help people achieve their goals. The home operated a keyworking model where each person had a named member of staff who led on reviewing and updating care files. Keyworkers also offered a main point of contact for people to talk about any issues or concerns they had. Keyworker meetings took place each week and people were supported to think about what was working well and what needed to change. Care files were regularly updated to reflect changes in people's needs. This ensured staff always had clear, up to date information about how to support people.

The provider had introduced an online care planning and record keeping system called Nourish. Staff were able to access care plans and record care delivered from mobile devices. Each day was broken down into different timelines and staff recorded the support they provided and any additional notes about how people had been during the day. The system allowed for changes to be made and shared with the staff team very quickly. For example, when one person required a temporary increase in their care and observations the timelines were updated and staff demonstrated they followed the amended care plan.

People had individual schedules for activities and domestic tasks. These were updated and reviewed regularly. For example, one person had initially agreed they would go to the gym once a week but records showed they had been choosing not to go. The gym activity was reviewed and changed to something the person wanted to do.

People attended a wide range of activities in their local community. One person was very active in a local arts group and their artwork was on display throughout the home. Two other people attended a conversation group for people who had had strokes. The registered manager explained how they had found this group. They said, "We were in the garden talking to our neighbour. They asked if we knew about this group, it's community run. We didn't, but after they mentioned it we found out about it. Two of the guys go regularly now and really enjoy it." This meant the service worked with the local community to find opportunities for people to be involved.

People told us they knew how to make complaints. One person said, "I'd tell [registered manager]. He would sort it out." The provider had a clear policy which outlined the process for making complaints and expected timescales for response. We reviewed records of complaints and saw the registered manager had completed through investigations and made changes to address people's concerns. For example, handover procedures had been made more robust following a relative's complaint that their visit had not been diarised which had meant they had not seen their relative.

People were given opportunities to provide feedback about the quality of the service through house meetings. Records showed people made suggestions for different things they could do and these were taken on board. The home had recently held a coffee morning for people and their families to increase the opportunities for families to provide feedback about the service.

No one living at the home was approaching the last stages of their life. The provider had a policy regarding end of life which included details of how to support people to plan for the end of their lives in a sensitive way. The policy also included details of the practical steps staff must take in the event of someone's death. Care files showed people had expressed their views about their funeral arrangements and any cultural or religious ceremonies they would like to be performed. We spoke with the registered manager about developing the plans over time to ensure they included more information about treatment decisions and preferred place of death as people shared their views about this.

Good

Is the service well-led?

Our findings

In August 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes had not identified or address issues with the quality and safety of the service. The provider had taken effective action and was now fully meeting this regulation.

People and staff spoke highly of the registered manager who demonstrated person centred values in his approach to all aspects of his role. One person said, "I like [Registered manager]. He's good." We saw people approached the registered manager easily throughout the inspection and observed relaxed interactions. We could see the registered manager took time to listen to people when they spoke to him. Staff told us they found him supportive and approachable. One care worker explained, "It's really good working here. The manager is very supportive." Another care worker said, "[Registered manager] is really helpful. He'll show me how to improve and will tell me if I'm doing well. This is my first job in care, and he made sure we had a catch up after a week to check I was doing OK."

The registered manager demonstrated an inclusive approach in his language and actions. He took a flexible approach to ensuring all the people living in the home were engaged in developing plans for the future of the service. For example, regular house meetings were the usual format for making plans about events, holidays or re-decoration of the service. However, one person did not like to attend these so was given additional keyworker sessions to ensure their feedback was captured. The registered manager explained, "House meetings are too formal for [person]. He doesn't like them but he has brilliant ideas so we make sure we ask him and keep him involved."

People and relatives were invited to complete quality surveys to give feedback about their experience of the service. The responses were analysed and any actions were added to the home's improvement plan. The registered manager had noted that only two surveys were received from relatives and did not feel this was sufficient feedback. In response to this they organised a coffee morning to provide an additional route for relatives to provide feedback. Relatives had completed feedback about the coffee morning saying they had found it useful and had liked having the opportunity to meet other families. This demonstrated the registered manager was committed to gathering the views of people and relatives and took a flexible approach to ensure feedback was comprehensive.

The registered manager also demonstrated the value he placed on his staff and the respect he held them in. For example, he distributed his performance bonus across the staff team in recognition that the improvements that had been made were because of team work not just his actions. The registered manger told us they had met with the provider after the last inspection and gone through the report in detail. He said the provider had been supportive and they had worked together to develop and monitor an action plan to improve the service.

The systems in place to monitor the quality and safety of the service were now robust. The staff team completed audits and checks on different aspects of the service. There were routine health and safety,

maintenance and medicines checks completed by a range of staff. Any actions required were included in the home's development plan which meant the registered manger could monitor when things were completed. Routine maintenance was now completed in a timely manner.

The registered manager maintained a document called the service improvement plan. All actions from internal and external audits were added to this plan, and the registered manager and their manager monitored progress against actions. The plan included both actions needed to ensure safety, for example replacing the thermometer in the medicines room, as well as actions to improve the quality of people's experience of care. For example, the service had recruited care workers who spoke the same language as one person, but had faced difficulties finding staff who could speak another language. The action to increase the range of staff who could communicate with people in their first languages remained on the plan as the provider recognised this was an ongoing piece of work.

The provider had systems in place to ensure consistency across the different services and engagement of staff teams. The provider had a number of services based in the local area. The registered manager told us they had monthly meetings with their peer managers. We could see that the registered manager had taken on board feedback given to other locations at their inspections. For example, where another service had received feedback about their application of the Mental Capacity Act (2005) checks had been carried out at Chandos Road to ensure they were working appropriately. The registered manager told us they found these meetings helpful as they were also a peer support and problem solving space where they could share challenges with other managers and think about different ways of approaching issues.

In addition to local meetings, the registered manager told us they attended quarterly meetings with managers of all the provider's services. Although Chandos Road is the provider's only service specialising in providing support to people with acquired brain injury, the registered manager told us they found these whole organisation meetings useful. They were used to ensure all managers were up to date with the provider's policies and systems as well as best practice in the field.

The service held regular staff meetings, where people's needs were discussed as well as ideas for any developments or activities people may wish to be involved with. Staff meetings were also used as an opportunity to reinforce learning from training and to share policy updates. In addition, the provider had introduced an organisation wide staff forum for support workers to raise issues that affected them as employees. A staff member said, "It was really good. We went to the head office and were able to talk about things that affect us as support workers." This meant the provider had systems in place to ensure staff were engaged with the organisation's development.

Following feedback at our last inspection, the registered manager and provider had applied for and achieved accredited status as a Headway Approved Provider. Headway is the brain injury association and they provider an approved provider scheme which assesses and accredits providers of brain injury services. They assessed the provider against the six domains of communication, culture, development, governance, quality, and both the physical and psychological environment. Their report recognised the progress made since the service had failed to achieve accreditation on a previous assessment. The home was working on the recommendations made for further development made in the report. The accreditation lasts for two years, and future accreditation relies on services staying up to date with best practice in the field. The registered manager told us they had found the process of accreditation very helpful. He said, "When I look back and some of the support we were providing I am a little bit embarrassed. We were trying but we didn't really know what to do. Now I know where to look and you can see the difference it is making. [Person] gets less frustrated now, because the work we are doing is actually helping."