Select Lifestyles Limited

Select Lifestyles Limited - 512-514 Stratford Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 30 June 2016 and it was announced. We gave the registered manager 24 hours of our visit, so they could ensure that staff and people who used the service would be available to speak with us.

Select Lifestyles Limited is a residential home which provides care for up to six people with a learning disability in Solihull. At the time of our inspection there were six people living at the home.

The service had a registered manager who had been in post since 2014. 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.

Relatives and staff told us people who used the service were safe. Staff had a good understanding of what constituted abuse and knew what actions to take if they had any concerns. Risks to people's safety were identified and ways to how to manage and reduce these risks were documented.

There were enough staff to care for the people they supported and checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service. Staff received an induction into the organisation, and a programme of training to support them in meeting people's needs effectively.

People and relatives told us staff were caring and had the right skills and experience to provide the care required. People were supported with dignity and respect and people were given a choice in relation to how they spent their time.

Staff encouraged people to be independent. Care plans contained information for staff to help them provide personalised care.

People received medicines from senior staff who were trained and medicines were administered safely.

Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making, which included arranging further support when this was required.

People had enough to eat and drink during the day, were offered choices, and enjoyed the meals provided.

People were assisted to manage their health needs, with referrals to other health professionals where this was required. Some people felt that referrals were not always made in a timely way by the management team.

People had enough to do to keep them occupied and staff tailored activities to people's individual interests.

People knew how to complain and complaints were documented and responded to. People were given the opportunity to feedback about the service they received.

Staff had mixed views as to whether they could raise concerns with the management team and whether they were approachable. There were formal opportunities for staff to do this at group and one to one meetings. Some staff felt that they would like to do more to support people at the home such as updating care records and administration of medicine.

There were processes to monitor the quality of service provided. There were other checks which ensured staff worked in line with the provider's policies and procedures.

Checks of the environment were undertaken and staff knew the correct procedures to take in an emergency.

We had not received all the notifications required, to enable us to monitor the service.

Following our visit we received some further concerns from staff about the management of the service which we raised directly with the provider. They agreed they would discuss this with staff further.

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 received their medicines from senior staff who were trained and competent. Staff had a good understanding of what constituted abuse and knew what to do if they had any concerns. There was a thorough staff recruitment process and enough experienced staff to provide the support people required. People received support from staff who understood the risks related to their care and how to minimise these.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making. People were supported with their nutritional needs. Managers referred people to other professionals if additional support was required to support their health or social care needs. Some people felt this was not always in a timely way.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Relatives told us staff were caring. People were encouraged by staff to be as independent as possible and given choices about how they spent their time. Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received a service that was based on their personal preferences and their keyworkers knew them well. Care records contained detailed information about people's likes, dislikes and routines and people were supported to pursue their hobbies and

interests. Complaints were recorded and responded to by the registered manager.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some people and staff felt supported by the management team, however others did not. There were formal opportunities for staff to discuss issues or concerns at meetings, however some staff did not feel that managers were always approachable. There were effective systems to review the quality and safety of service provided. People living at the home had opportunities to feedback any issues. We had not received all the notifications required about changes to the service. □

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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 took place on 30 June 2016 and was announced. The inspection was conducted by one inspector.

Before our visit we reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We looked at information received from relatives and visitors.

We spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They made us aware of a recent complaint at the home.

Most of the people living at the home were unable to share their experiences of the care and support provided. We spent time observing care in the communal areas over the lunchtime period.

During our visit we spoke with one person and two relatives, one over the telephone. We also spoke with one health professional who was visiting the service on the day of our visit. We also spoke with eight staff including six support workers, a team leader and the registered manager.

We reviewed three people's care records to see how their care and support was planned and delivered. We checked two staff files to see whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service

operated, including the service's quality assurance audits.

Good

Is the service safe?

Our findings

Staff told us people were safe living at the home. One staff member told us, "People are checked, if we see some equipment or something is a danger, we make it safer for people." The team leader told us, "If ever I feel there are needs with people's safety, I talk to [Registered manager]."

Staff undertook assessments of people's care needs to identify any potential risks when providing their care. Risk assessments were updated by the registered manager when people's needs changed. One staff member told us, "We contribute to the risk assessments; we go to the manager or a team leader if they change." The registered manager told us they liked to be sure risk assessments were kept up to date and so took responsibility for this. We saw risk assessments in place in relation to personal care, managing continence needs and managing money and finances. Some risk assessments were not dated, so we could not be sure they were current. We asked the registered manager about this and they told us, "I will do that now."

One person was at risk of falls and had fallen on several occasions at the home. One staff member told us, "At the moment the issue is when they are walking they need assistance, they need to be supervised as they are at risk of falls." Although staff had some understanding of how to support this person, there was no risk assessment in place for this person so staff had information on how to minimise this risk in a consistent way. The registered manager told us they were in the process of completing this risk assessment now.

Prior to staff starting work at the home, the provider checked their suitability to work with people who lived there. Background checks were obtained by the provider and references were sought. One staff member told us, "I had all my checks and had to give two references." We checked two staff files and saw these had been completed. The registered manager told us about the interview process, "People will answer what they think you want to hear, so it is about trying to assess them, and we have a three months trial period." This ensured as far as possible staff employed were suitable to support people.

There were enough staff available to meet people's needs. One relative told us, "They have got lots of staff." One staff member told us, "It is about right with staffing, we get it all done." Along with the registered manager, 13 staff were employed at the service. Two staff worked during the night. One person worked as 'bank staff' and was employed at the service 'as and when' required. One person's needs had increased, so they were being reassessed. The registered manager told us this may result in them needing to increase staffing further, and the provider was supportive if they needed to do this.

Staff understood the importance of safeguarding people and their responsibilities to report any concerns. One staff member told us, "If I had an issue, if somebody was at risk I would report it to the team leader or if not the manager or head office. If it was an immediate risk I would contact the 'safeguarding' team (at the local authority). I would follow it up. The phone number is displayed." The person went on to explain, "Abuse could be financial, physical, sexual abuse or neglect." Another staff member told us, "There is safeguarding team in Solihull or I would report any concerns to the head office." The team leader told us, "I know about safeguarding and the steps to take. It could be emotional abuse or bullying. I can talk to the

manager, head office, the Police or social services."

Staff were aware of what whistleblowing meant (raising concerns about the service) and how to report these. One staff member told us, "There is a policy, if you feel you have any concerns, you need to voice them." Following our visit, a staff member contacted us with a concern of a safeguarding nature and we contacted the provider about this, who agreed to investigate further.

We looked at how medicines were managed and found overall they were administered and stored safely. The team leader told us, "We ring the doctor, order the medication and book it in." One relative told us, "I feel [Person] at times takes the medicine too late or it is forgotten." We asked the registered manager about this and they told us sometimes the person chose to get up later, so this is why their medicine was administered later.

Senior staff administered medicines. Support workers administered medicine in the form of creams. One staff member told us they were trained to give medicines, however they were unable to do this. We asked the team leader about this and they told us, "In the past some staff were making mistakes, so if the seniors or managers do this, it reduces the room for error." They went on to say, "When there is a lot of medication, it is too much for support staff, they might get confused." We discussed this with the registered manager who told us previously there had been some medicine errors and so senior staff now administered medicines; however they would consider whether other staff should be able to do this again now.

Some people had medicine 'as required', for instance when they were in pain. We asked the registered manager what happened if people were in pain at night and there were no senior staff working. They told us the night staff were able to give this medicine. Guidelines were documented on people's care records, so staff knew when this medicine was required if people were not able to say, so staff were able to support them correctly.

One person had an emergency medicine due to a health condition which only senior staff administered. The registered manager told us if the person required this in the night, when senior staff were not working, an ambulance would be called. This had been agreed with the prescribing professional involved.

The team leader encouraged one person to take their medicines with yoghurt to make this more palatable. We observed them gently encouraging the person to take this. We asked them what they would do if people refused medicine. They told us, "[Person] will refuse them, we go back to them later, it can take a bit of coaxing and they will take it then."

Some medicine was in the form of creams, applied to people's skin. We saw a cream had been opened, however it was not dated on opening. This posed a risk that the cream could be used when it was out of date, and so less effective. On one medicine administration record we saw in the afternoon, a cream had been recorded as being applied that evening, and the record had been completed in advance. The team leader told us this has been recorded in error. Inaccurate recording meant there was a risk that the person may not have the cream applied correctly.

A medicines audit had been completed in March 2016 by the clinical commissioning group. Some improvements had been suggested such as purchasing another thermometer to record temperatures. These actions had been completed.

Staff were aware of the procedures to take in an emergency and if the home required evacuation. One staff member told us, "We do have a fire drill. Some people would stay in their room in an emergency. There is an

emergency 'bag' behind the door. We would then meet in the car park." Fire tests were completed weekly along with fire drills, to ensure staff knew what to do in an emergency. Fire evacuation procedures were documented in an 'easy read' pictorial format for people at the home. Personal emergency evacuation plans detailed people's individual needs, so staff could support them effectively. Fire safety checks had been completed in February 2016.

Accidents and incidents were recorded for each person and these had been analysed to identify any trends and prevent these from reoccurring where possible.

A handyperson service was available if any repairs were required. Safety checks of the environment were completed such as gas safety, electrical and water checks. Risk assessments were completed in relation to the environment to identify any potential hazards. Restrictors had been fitted to windows, and equipment had been serviced regularly to ensure it remained safe to use.

Requires Improvement

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. One relative told us, "I think [Team leader] and the staff are good. I think there is a good team."

Some people were supported to manage their health conditions and had access to health professionals when required. However, some people told us that they felt this was not always arranged in a timely way.

One health professional told us staff contacted them if they had concerns about one person's skin or rang the GP. They told us, "Staff manage well, they do address things, they record it and report it." Another health professional visited monthly to check one person's skin as this was at risk of damage. The registered manager told us about this person and that there were no problems with their skin currently. A specialist bed and mattress were in place to support this person further.

One person had been referred to an 'intensive therapy' service to assess them further and gain a better understanding of their needs. Another person accessed the speech and language therapist for assistance around eating. Other referrals were documented for health appointments such as the optician. During our visit we saw one person appeared unwell and had recently fallen. A referral had been made to the community falls team for further assessment.

Relatives had mixed views about whether people were seen by other professionals in a timely way. One relative told us, "It's hard work with appointments," and they said they did not always feel supported in arranging this for their family member. They told us their family member had lost weight and they did not feel this had been checked regularly enough. The provider and registered manager were meeting with the family member to discuss the issues raised.

One person had a specialist chair provided. One staff member raised concerns with us that sometimes equipment had been purchased and people had not been properly assessed for this. We raised this with the provider who told us they would investigate this further.

One staff member expressed some concerns that a person had fallen, and they did not feel they had been seen by the doctor quickly enough. They told us, "We do not always make the decisions." We asked the team leader about this and they told us the person had recently been taken to the doctors following a fall. Another staff member told us, "I don't think people are referred quickly enough to the doctor, we keep telling them (managers) but they don't do anything about it until the last minute. Pretty much everything is delayed. I don't think they like people to interfere."

Another staff member told us they felt the manager wanted to keep the service 'away' from other professionals and to not involve other people. They went on to say they did not always feel listened to in these situations. They told us, "If we are brought in as a worker, we should be allowed to take a bigger part in people's well – being." They gave another example of when one person required some cream for their skin condition and there was a delay to arrange this by the management team which worried them.

We asked the team leader about this and they told us, "Certain support workers will ring the doctor themselves. They don't have to have permission, but they will let the senior or manager know." They went on to say, "In my appraisal I have said I would like some of the staff to make calls (to health professionals), it would build their confidence up."

We raised these concerns with the registered manager who told us they did like to take control, as they had the overall responsibility for people's care. However, they agreed that perhaps staff could take more of an active role with referring to other professionals.

Staff received an induction when they first started working at the home. The registered manager told us, "There is no limit to how long staff shadow (work alongside) other staff, we do this until we are happy." One staff member told us, "When I had my induction I met people, we went thought a tick list of policies, where to find things. We looked at health and safety, and I did some shadowing, which was enough." An induction sheet documented when the induction learning was complete. New staff were given a job description which detailed their roles and responsibilities.

Staff received training suitable to support people with their health and social care needs. The registered manager told us this used to be based more around training DVD's, however they did not feel this was always effective and so now, the training was more 'face to face'.

Training had been completed in areas such as moving people safely. One staff member told us, "I've done health and safety training, it is on-going. I did moving and handling training, it was all new, I've never used a hoist before, as long as you have the right equipment it is not too hard." Another staff member told us, "I have been doing quite a lot of training, I did 'self-harm', the Care Certificate and medication training. For the self- harm training, it gave me a better understanding of how to help someone."

One staff member was unhappy about the 'refresher' training. They told us, "Managers write on a piece of paper to say we have had a refresher. They ask us if we still feel comfortable (with our skills)." They did not feel this was adequate.

All new staff completed the Care Certificate. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment. The registered manager told us they had started with the new staff, and now all staff were completing this as a refresher training. This consisted of three days training at the head office and staff observations and assessment were undertaken by the registered manager and provider. One staff member told us about this, "The Care Certificate is going fine. It's a different angle, it is quite a bit of work, but you do learn new things."

A 'handover' meeting was held each day as the shift changed, where information was shared by staff about people's health or well-being, so people could be supported consistently.

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. 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 (DoLS) were

being met. We found five of the people living at the home were having their liberty restricted. Decisions had been correctly taken to submit applications to a 'Supervisory Body'. At the time of our visit all of the applications had been submitted or authorised.

One person at the service did not have a DoLS in place and we asked the team leader what they would do, for example, if they chose to go out unaccompanied. They told us, "We would usually accompany them, but we would have a best interest meeting. We would weigh up their understanding, involve the GP. If people want something we encourage them the best we can."

Most people at the home could make some day to day decisions. For one person they could smile or frown to indicate their choices, and staff were aware of this. Another person had the capacity to make most decisions for themselves. One person at the service refused to be weighed and the manager told us they had the capacity to make that decision. One staff member told us, "Our policy is that we always see if people have got capacity, and it could be limited or full. We let people make decisions." Another staff member told us, "We cover this in the Care Certificate. People that have capacity can make their own decisions. If people have decisions made for them, it needs to be in their best interests." We asked the team leader about mental capacity and they told us, "It is whether the person has the capacity to make a decision or not. There are five principles. You need to consider the person's impairment and if they can decide."

Staff sought consent from people before supporting them with care. We observed a staff member asking one person if they would take their medicine, and they explained what this was, before supporting them with this. Consent forms were documented on people's care records and these had been completed correctly and signed by people where they were able to consent.

People's nutritional needs were met with support from staff. One staff member told us, "Those people that are able to, tell us what drinks and food they want. We have menus if people are not sure, we show them pictures to help them decide. They can have what they want, we do give them options." A seasonal menu was provided and people were given choices from this. The registered manager told us, "We try not to stick to this too rigidly. We know what people like and don't like." One person liked their own menu and did not like to eat what other people had, so staff supported them to choose separately. Food shopping was delivered weekly.

We observed people over the lunchtime period, enjoying their meal and being supported by staff at their own pace. People who had special dietary needs were supported. One person required food to be liquidised and their drinks thickened, due to a medical condition and staff supported them with this. The registered manager told us this person could indicate to staff when they had had enough to eat.

Good

Is the service caring?

Our findings

People told us staff were caring. One professional told us, "You can tell by the body language of staff, I have never had any concerns, they are caring, and very welcoming to me." One relative told us, "I think [Person] gets the best care, there is lots to do, the place is clean, they look clean and their room is immaculate." They went on to say, "I'm really happy, I'm glad it is a good home."

We observed staff supporting people with kindness during our visit, being respectful and encouraging to people. One person had been in hospital recently and staff had arranged for other people at the home to visit them during their stay.

Staff told us they felt their colleagues were caring. One staff member told us, "You have to be caring to be in the job. It is about communication." They gave an example that one person had felt unwell that day and this had been reported straight away. One staff member told us about working with the people at the home, "I love my job." Another staff member told us, "I do try to give the service users as much as I can." Another staff member said they felt the staff were all caring in their approach to people.

People were allocated a named worker they were familiar with, called a keyworker. Their role was to source activities for people, assist people to appointments, and support them with buying personal items such as clothing and toiletries.

People made choices about how they spent their day. One staff member told us, "It's flexible here for people, for instance people can get up when they want to."

People were encouraged to be independent. Two people used the lift at the service independently and we saw one person access this and go up to their room. One person helped with the household chores as part of their daily routine. Other people helped to make drinks and prepare food.

People were encouraged to keep in touch with their families and there were no restrictions on visiting times. Some relatives visited each week, others monthly and some kept in touch by telephone. Another relative visited each day and took their family member out. Staff had taken one person to visit a relative who was unwell, to keep them in contact with each other.

An electronic tablet computer had been purchased for people to use to talk to relatives who did not live locally. The registered manager told us, "We do try to include people as much as we can." Some social events took place involving families such as burger and curry nights, and a coffee morning. One event had raised funds for a local children's charity.

Most staff supported people with privacy and dignity. One staff member told us, "If we go into a room we knock first and ask if it is okay to come in. We keep people's dignity with personal care, it is done in a private place with the curtains closed." However, on one occasion we saw a staff member walk directly into a person's room who was sleeping, disturbing them. This did not provide the person with privacy. We raised

this with the registered manager, who told us this was an error and would not usually happen.

Some people were supported with an advocacy service in relation to their communication needs and finances. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to enable them to make a decision.

People's rooms were individualised, contained their own personal items and people were encouraged to make these comfortable to suit their needs and preferences.

Good

Is the service responsive?

Our findings

People we spoke with were positive about the support received by people living at the home. One professional told us, "I think the staff know people well. I look at them and how they react with staff, how happy they are and what they are doing with them." One relative told us, "I feel [Person] is getting more care there, more one to one support."

Staff knew people they supported well. One staff member told us about one person, "[Person] can dress themselves, make a drink and breakfast, they will voice concerns if they are not well, they love playing dominoes and cards, colouring, doing sewing cards."

People were supported by consistent staff. One staff member told us, "People do see the same staff, there is not a high turnover. People don't like changes."

Care records contained information about personal care needs, routines and preferences. Records were updated by the registered manager when people's needs changed and we saw these had been reviewed recently. One person had a serious medical condition. Records were kept regarding their health and any changes, so that staff and other professionals could monitor the person's health and ensure they were supported to manage the condition.

Care records were 'person centred' and contained information including people's life stores which enabled staff to know them better and how to support them. One person at the home was cared for mainly in bed and this was their preference. The registered manager told us, "They do not like to get up." The person's room had been designed with some sensory equipment to provide some stimulation for them. Staff supported them by sitting with them, listening to music and sometimes they were supported to go out for lunch.

Preferred communication styles were documented. For example, one person used Makaton, which is a form of sign language, to make day to day choices. Care records contained goals for people and for one person this was to go on more holidays. For another person, it was documented it was important to have an environment with 'not too much noise'.

People's care plans were reviewed regularly. The provider met with people's relatives to do this where people were unable to review their own care plans, or wanted their families to be involved. Care records showed a review had been carried out for one person in November 2015.

There were some social activities to keep people occupied. One relative told us, "[Person] goes out a lot." One person had been going swimming and having some sessions of aromatherapy which had been on the advice of a professional, who felt this would benefit them. Another person enjoyed visiting a farm each week. One person liked to go to the pub when possible. The registered manager told us another person did not like going out as much and preferred to go for a drive to a local lake or visit a garden centre.

On the day of our visit, two people were visiting a day centre where there were some activities held. One person told us, "Yes I have had a nice day today," when they returned from this visit.

We looked at how complaints were managed by the provider and found these had been recorded and responded to. One relative told us, "I don't think there is anything to complain about. The management are approachable, if you complain. They make time for you."

We saw some complaints relating to a broken appliance. One person who lived at the home had complained about a piece of furniture breaking, and this had been recorded with a response given. These had been investigated and responded to. There had been a recent complaint by a relative about their family members care and this was being investigated currently. This was in relation to medication, activities and management. Some compliments were recorded. One relative said their family member 'had never been looked after better'.

Requires Improvement

Is the service well-led?

Our findings

There were mixed views about the management of the home. One professional told us, "I know [Registered Manager], they are good." They went on to say, "I think it's well led, with staff there is a nice relationship." One staff member told us, "I can approach [Management] and they are open to new ideas. I think it is run quite well, you can make suggestions." Another staff member told us, "I am happy with how the service is run. I have no issues. If I felt there was an issue I would complain." Another staff member told us, "I quite like where I am, the staff are good, the work is shared out, I feel supported by other staff. I always talk to the managers."

One relative told us, "I think it is very good, I'm impressed. [Person] is very happy there and I can't fault it. I've got no concerns." They went on to say, "If I've got any concerns I could go to the manager. They are really good." However, one relative did not always feel supported and told us, "I don't think they want relatives to come in," as they had not always felt welcomed.

Some staff told us the management team were approachable, however other staff felt they were not always. One staff member told us, "Yes, [Team leader] is approachable. There is a feeling of control with the management. It is a bit disempowering and undermining. I don't feel there is a lot of potential." One staff member told us they could talk to a team leader, but did not feel they could raise issues with the manager. Another staff member told us, "I have got concerns working at the service. I am not happy working there due to the management. I rate [Team leader]. That is the only reason I have stayed." Following our visit we received some further concerns from staff about the management of the service which we raised directly with the provider. They agreed they would discuss this information with staff further now.

Some staff told us they felt they were not able to support people fully. One staff member told us, "The seniors and manager update the care records. I would like to put my own input into them." The team leader told us staff did not update care records and the registered manager did this. However, if staff felt there was an amendment they would record this on a 'post it' note in the file for the registered manager to review. This posed a risk information could be lost and would not be updated correctly. We raised this with the manager who agreed this system could be more robust and they would review this.

The management team consisted of the registered manager and two team leaders. The registered manager told us, "I've got two team leaders that are excellent." One team leader told us, "Yes I feel supported, I'm in the 'middle', I can raise things, if I don't think it is going anywhere, I would contact head office."

Staff had formal opportunities to meet at team meetings and in one to one meetings with their managers. Team leaders supervised support workers. The registered manager told us, "We do have team meetings, the last one was February or March time, they are minimum of two a year." We saw at the meeting in February 2016 staff had been reminded about confidentiality and the importance of supporting people with dignity and respect. A senior staff meeting was also held every two months and the last one was in June 2016 where one team leader had been thanked for covering some additional hours.

One to one meetings were being held every month to support staff. One staff member told us, "They are approximately once a month with [Team leader]. It is useful we might talk about more training, it is constructive." However, another staff member told us they had raised some things at supervision, but felt they had been 'brushed under the carpet'. The team leader told us, "I think supervision is useful. It can change your practice and you might identify extra training is needed."

Appraisal meetings gave staff the opportunity to review their roles, and look at their training needs and goals. The registered manager told us, "I do appraisals four times a year." They explained one was an observation, and a group 'supervision' (staff met together in a group to talk about any issues they had)." We saw management observations had been documented on some staff files.

The registered manager told us they felt supported in their own role. There had been a recent change in their own manager, however the provider was available to support them when required. The registered manager told us they were the only home in the provider's group, as the other services were 'supported living' services. The registered manager told us, "I feel completely supported by [Provider], they are brilliant, I cannot fault them."

The registered manager told us about challenges at the service. They told us that when they first came to work at the service in 2014 the staff team were inexperienced and there had been no manager for a period of time. There had been a large turnover of staff, but now they felt staff were more settled. They told us they had tried to develop training further. Also they were much more 'hands on' in their role. They told us, "I do management observations and work as a second carer."

The registered manager told us what they were proud of. The home had recently been refurbished. The registered manager told us, 'The house is how I wanted it." They told us that the new staff had a good attitude and the team leaders were 'great'. The team leader told us, "There is always room for improvement, it is organised enough. Whenever things do need changing, we take steps to do this."

People at the home had an opportunity to meet and discuss any issues or concerns they had. A meeting had been held in April 2016. It had been discussed about choosing colours for people to decorate their rooms.

Audits and checks of the service were carried out by the management team. The team leader told us, "I do audits for the fire alarm, wheelchair checks, water checks of temperature, legionella checks." Other checks included medicines audits, checks of care records and of other safety checks. The provider carried out monthly audits at the service.

A recent visit from the clinical commissioning group had made some recommendations around improving the environment and decoration at the home, and this had now been addressed.

The registered manager understood their responsibilities and the requirements of the provider's registration. They were able to tell us what notifications they were required to send us, such as changes in management, safeguarding and incidents involving the Police. However we found that we had not been informed of a safeguarding incident and had not been informed of a serious injury that occurred. The registered manager told us this had been an oversight and they would ensure we would be notified of these incidents in the future.