Cheer Health Limited

London Road Neurological & Specialist Care Unit

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

Overall summary

This inspection took place on the 2 and 4 February 2015 and was unannounced.

London Road Neurological and Specialist Care Unit provides accommodation for up to 49 people who require personal and nursing care and is based over two sites, one being across the road from the other. The service provides care for people with genetic or acquired brain injury as well as for degenerative conditions. At the time of our inspection there were 34 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff working at the service had a good understanding as to their role and responsibility in reporting any suspicions or reports of abuse. Information was displayed within the service as to what action people and staff should take and this supported by the provider's policy and procedure.

People's records included assessments that identified areas of potential risk. Where risks had been identified measures had been put into place to minimise risk which ensured people were kept safe and their care, treatment and support was managed safely.

People were cared for by staff that were employed in sufficient numbers and who had the appropriate skills and knowledge to meet people's care, treatment and support needs.

People were administered medication in a timely manner. Medication prescribed reflected their needs which promoted their health and wellbeing. Medication was administered by nursing staff who had their competency regularly assessed. Monitoring systems were in place to ensure people's medication was managed safely.

People were supported by staff who had the appropriate knowledge, skills and experience to provide the care, treatment and support they required. Staff had their competency regularly assessed to ensure they provided care based on best practice, through observed practice, supervision and appraisal. Staff had an induction period and accessed regular training.

People's plans of care included information as to their capacity to consent to their care and treatment. Where people had been assessed as not being able to consent their relatives and supporting health care professionals documented the care they believed people should receive after considering their best interests. Where people were able to consent to their care and treatment this was always sought by the staff before any treatment or care was carried out. We found people and/or their relatives had in many instances agreed that they should not be revived through cardiac pulmonary resuscitation and the appropriate forms were in place, however we found many of these had not been signed by a doctor and were therefore invalid. We spoke with the doctor about this. We received confirmation from the registered manager that the forms had been signed by a doctor following our inspection.

People we spoke with and their visiting relatives were complimentary about the attitude and approach of staff. They told us that staff were caring and supportive and provided the care and treatment required. We found staff to be knowledgeable about the needs of people and we observed them involving people, where possible, in the care and treatment they received. People's dignity and privacy was both promoted and respected and our observations showed staff putting this into place when providing care and treatment.

People received personalised care which was recorded within their individual plans of care and reflected their assessed needs. Plans of care were in place should people's health quickly deteriorate, which included access to prescribed medication to be used in the event of specific circumstances. This enabled staff to respond quickly to the changing needs of people.

The provider, management team and staff had a system for reviewing incidents within the service and were used to review nursing and care practices as well as reviewing policies and procedures. This enabled staff to continually develop their skills and learn from events to improve the service people received.

There was a complaints procedure in place and people we spoke with were confident that any issues raised had been or would be dealt with well.

The provider and management team had an 'open door' policy which enabled staff to approach them with any concerns. We observed that members of the management team which included the director, general manager, registered manager and training manager were highly visible within the service, which meant they were available to speak with people who used the service, relatives and health professionals. Formals systems were in place to enable staff to engage with the management team through meetings, supervision, appraisal and on going competency based training.

Summary of findings

Monitoring systems were in place to check the quality and safety of the service provided which included reflective practice and learning from events as well as the maintenance of equipment and the environment.

Summary of findings

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 protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing had been assessed and measures were in place to ensure staff supported people safely.

There were sufficient numbers of staff available to keep people safe who had the appropriate skills and knowledge. Staff had been appropriately recruited to ensure they were suitable to work with people who used the service.

People's medication was stored and administered safely by nursing staff whose competence to administer medication was regularly reviewed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate knowledge and skills to provide care and who understood the needs of people.

Staff were supported by the management team through supervision, appraisal and on going training.

Staff followed the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as recorded within people's assessment and plans of care ensuring people's human and legal rights in relation to care, treatment and support were respected. We found people and or their relatives had in many instances agreed that they should not be revived through cardiac pulmonary resuscitation and the appropriate forms were in place and had been signed by a doctor.

People were supported to maintain their health through the appropriate intake of nutrition and hydration based upon their individual assessed need.

There were positive working relationships between health care professionals and the service. People were referred to the relevant health care professionals in a timely manner.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives were supported by staff who had developed supportive relationships which focused on an inclusive approach to care.

People who used the service who were able to express their views were actively involved in decisions about their care and treatment. People who were unable to express their views had decisions about their care made by people's next of kin and health care professionals.

People received care by staff who promoted their privacy and dignity.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People received care, treatment and support that reflected their assessed needs and was regularly reviewed. Plans of care were in place which identified treatment and care where people's health deteriorated quickly.

The provider had a complaints procedure which was accessible to those using the service and their relatives. People were confident to raise concerns and said issues raised were dealt with.

Is the service well-led?

Good

The service was well-led.

A registered manager was in post. The registered manager, management team and staff had a clear view as to the service they wished to provide which focused on promoting people's rights and the provision of good quality care.

The director and registered manager had a comprehensive understanding of the service and were visible within the service. The management team were proactive in the development and leadership of the service and were proactive in assessing staff competence and the provision of training.

The provider worked with health care commissioners who funded care packages for people using the service. Monitoring systems were in place to check the quality and safety of the service provided which included reflective practice and learning from events as well as the maintenance of equipment and the premises.

London Road Neurological & Specialist Care Unit

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 2 and 4 February and was unannounced.

The inspection was carried out by an Inspection Manager, Inspector and Specialist Advisor. The Specialist Advisor had experience working and caring for people with an acquired brain injury and degenerative conditions.

We spoke with four people who used the service and two relatives.

We spoke with the director, general manager, training manager, registered manager, three nurses, a member of care staff and a chef. We also spoke with a physiotherapist who provided support to some of the people at the service and a general practitioner.

We pathway tracked the care and support of seven people, which included looking at their plans of care to check that they were receiving the care they needed. We looked at four staff recruitment records and training records. We looked at records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

We contacted commissioners for health care who funded the placements of people at the service and asked them for their views.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to the Care Quality Commission.

We reviewed the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that providers must tell us about.

Good

Is the service safe?

Our findings

We looked at how the service protected people and kept them safe. The provider's safeguarding (protecting people from abuse) policy was displayed throughout the service and provided staff with guidance as to what to do if they had concerns about the welfare of any of the people who used the service. Discussions with staff showed they had a good understanding as to what action they would take if they believed somebody was being harmed or abused.

We spoke with a nurse and asked them about their understanding and role in protecting people from abuse and reporting abuse. They told us "Any concerns I would report to the registered manager or one of the directors, I am confident they would take the appropriate action." A carer we spoke with told us "I have not had any concerns here but if I did I know who to phone outside of the home. There is a whistle blowing policy and booklet in the staff room."

People's care records included appropriate risk assessments. These were regularly reviewed and covered areas of activities related to people's health, safety, care and welfare. The advice and guidance in risk assessments were being followed. For example, a person at risk of poor appetite had been referred to a dietician. Whilst for other people assessed at being at risk, they had been provided with equipment to keep them safe, such as bed sides to prevent them falling out of bed and the use of equipment to prevent and manage pressure sores. Staff had received training about how to use equipment. A member of staff told us "The training nurse trains all staff in new equipment and watches us before we can use it independently. For example we have recently had new bariatric equipment for the unit over the road."

People's safety was supported by the provider's recruitment practices. We looked at staff recruitment records and found that the relevant checks had been completed before staff worked unsupervised at the service, which included a check as to whether nurses were registered with the appropriate professional body. Records showed that the director and management team followed the provider's disciplinary procedures where staff were found to be providing care which was not of the standard required by the provider.

We spoke with the director and registered manager and asked them how they ensured there were sufficient staff on duty to meet people's needs. They told us that they considered people's needs as part of the assessment process before people moved into the service to determine the number of staff required to provide the appropriate care and support. The director told us there was flexibility within the staffing which enabled them to increase staffing numbers should people's needs change.

We observed staff supporting people during our inspection and noted people were supported in a timely manner, which meant there were sufficient staff on duty to meet people's needs. The rota and our observations showed that qualified nurses were on duty at all times and that they were supported by care staff. One person told us "They answer the buzzer quickly."

A nurse told us "The unit is well staffed most of the time, lots of carers have been hired recently so we no longer use agency staff." This was confirmed by the director. A second member of staff said "At the middle to the end of last year we used agency staff as quite a few staff left at the same time but they have been replaced now. Staffing levels are a lot better now."

During our inspection an issue of risk about a person's care was discussed and the director managed this by requiring a risk assessment to be undertaken. They stated that the person using the service was to be involved in the risk assessment and decision making process to ensure the person was aware of the issues identified and how to manage the risk. This showed that risks to individuals were managed and that people were protected and their views supported.

We received information from a health professional who commissioned the care of some people at the service. They told us that the staff at the service were skilled at looking after people that required a high level of nursing care as many of the people had a minimal conscious state.

One person we spoke with told us "I get my medication on time."

We looked at the medication and medication records of four people who used the service and found that their medication had been stored and administered safely. We looked at the records and storage of controlled drugs and found there to be an accurate record. (A controlled drug is

Good

Is the service safe?

one whose use and distribution is tightly controlled because of the potential for it to be abused.) This meant people's health was supported by the safe administration of medication.

We asked the director how people's medication was reviewed. They told us that the service had a dedicated general practitioner who reviewed the medication people were prescribed, to ensure people received the appropriate medication in order that their condition was managed safely.

Good

Is the service effective?

Our findings

We spoke with nurses and asked them about their knowledge and skills and whether their competency was regularly assessed to ensure good practice. A nurse told us "The training is excellent here. There is simply no excuse for poor practice."

A carer told us "Specialist training is advertised on a board in the staff room, for example dementia care and Parkinson's disease. We are responsible for putting our names down for the training. I have just had training about what to check if a feed pump starts to alarm."

We found the training manager to be very present in the care environment, they told us that it kept staff "On their toes and enabled them to challenge poor practice". They told us they carried out daily spot checks.

Staff had a three month period of induction upon their commencing employment at the service and this included working alongside the training manager, shadowing staff and included clinical supervision. A member of staff told us. "New staff work with the training nurse for the first three days. I have been involved in mentoring new care staff."

The training manager continually assessed staff competency throughout their employment. The training provided was practical and theoretical and took place at the bed side of people where appropriate, in groups or within the training room. Training was also sourced externally from organisations with specialist knowledge. Nursing staff undertook training specific to their role, whilst care staff undertook vocational qualifications.

The provider had obtained copies of the revised code of practice for nursing staff, which comes into force in April 2015, to ensure nursing staff employed have guidance as to best practice and behaviour.

We spoke with the provider, registered manager and nursing staff about the Mental Capacity Act (MCA) 2005 and (DoLS) and what they meant in practice for the people who used the service. They were knowledgeable about how to protect the rights of people who were not able to make or communicate their own decisions. People's plans of care showed that the principles of the MCA had been used when assessing people's ability to make decisions.

Records showed that where people did not have capacity to make decisions, evidence was in place within people's medical records and hospital discharge notes of the involvement of health care professionals, including nurse specialists and people's relatives. Records showed that decisions about people's care had been made in their best interests. We spoke with the registered manager about the implementation of best interest tool forms. They told us they would look to implement these consistent with good practice.

We looked at DNACPR (Do Not Attempt Cardiac Pulmonary Resuscitation) forms and found that eight had not been signed by a doctor and were therefore invalid. We spoke with the doctor, director and registered manager about this. We received confirmation from the registered manager following our inspection visit that the forms had been signed by a doctor.

One person we spoke with about meals told us. "Food is excellent, lots of choice and offered snacks in between."

Where concerns about people's food or fluid intake had been identified, they were referred to their GP, SALT (speech and language therapy) team and dieticians. People's weight was monitored in accordance with their assessed need and staff were aware if people needed extra support with their nutrition. People who required a diet which reflected their beliefs, culture or religion were supported to do so.

A small number of people using the service were able to eat and drink in order to maintain a balanced diet and we found nutritional assessments had been carried out. We spoke with the chef and found that people's dietary needs and preferences were known by them and were catered for. A majority of people using the service received their nutrition via an alternative method, which included via a feeding tube known as percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG). Records showed dieticians prescribed the regime for people who required feeding via a tube.

We found there were sufficient supplies of food for people to eat, which included items to encourage a healthy diet. The chef told us that there were no budget restrictions on the purchasing of food, which enabled them to obtain high quality foods and foods which people enjoyed.

One person told us "Staff always call the doctor when I am feeling unwell."

Good

Is the service effective?

People's care records showed that people were supported by a range of health care professionals, which included speech and language therapists, dieticians, tissue viability nurses, specialist nurses related to specific conditions which included Huntington's disease, multiple sclerosis and Parkinson's. In addition support was provided by physiotherapists, chiropodists, and clinical psychologists and psychiatrists.

Discussions with the director, registered manager and nursing staff evidenced a positive working relationship with health care professionals.

We received information from a health professional who commissioned the care of some people at the service. They told us that people's plans of care evidenced that people were supported by a variety of health care professionals.

Good

Is the service caring?

Our findings

People who used the service shared with us their views about the staff, including their attitude and approach to them. One person told us. "Staff are lovely" and went onto say that they treated them with dignity and respect and had provided support to their spouse who had found coping with the their illness very difficult. Another person said "My visitors are always welcomed and encouraged."

One person told us. "The staff always go the extra mile to ensure I'm comfortable. They ask 'are we doing things ok?'". Another person told us "I think they [staff] are alright, they come in and check on you."

People we spoke with confirmed the care and support they received and were fully informed about their health care plans. We found that where people were able to consent to their care and treatment they had signed their plans of care and risk assessments. A person told us that staff explained the care they were going to provide and were polite and considerate towards them. Another person we spoke with told us "Staff care for me as they should. I know all about my condition and what the staff tell me about it. I am very happy with the actual care, I am fully involved. I have been involved in my care plans. Staff wrote them and showed them to me."

A relative told us they had been visiting for many years. And said. "It's home from home." They went onto say that the staff were very supporting, stating "They made a horrific time much easier for us to bear." A second visitor told us that the staff were respectful and courteous and that staff engaged with them and their relative.

We spoke with a nurse and they showed us plans of care that were specific to a person's needs, which included management of their breathing and nutrition. We found the plans of care and records to be up to date and signed. They told us that they loved it here [place of work] as they provided the best care possible which meant they had real job satisfaction. We found that staff had developed relationships with people's relatives. One nurse told us. "I love my job. I feel the clients are looked after well and truly cared for. We know them and their families well and the staff have been here a long time. We are like a family."

During our inspection we heard and saw staff interacting with people in a caring manner, speaking with them whilst providing care and telling them what care and treatment they were going to perform; whilst maintaining their privacy and dignity. A majority of people remained within their bedrooms either in bed or in a chair due to their health care needs, whilst a few people accessed communal areas using their individually designed wheelchairs.

We saw information that was displayed in each person's bedroom, which stated 'I am a person. Please do not talk over me. Please remember I am a person like you. Treat me like you would want to be treated.' A nurse told us. "Most clients are unable to communicate but we talk to them all the time, we always say what we are going to do, and why."

The director told us about the links the service had with different religious and faith groups, who visited people at the service as per people's wishes and included the observance of religious practices at the time of a person's death. The director within the provider information return provided examples of how people's individual cultural needs had been met. People's views regarding end of life care, including advanced decisions made, which included where appointees with lasting power of attorney were involved and were kept within people's records. This ensured that peoples' preferences and choices for their end of life care were acted upon.

Information provided within the provider information return stated that a majority of people at the service had an advanced decision in place with regards to emergency treatment and resuscitation. In some instances these decisions had been made by people who represented them and who had a lasting power of attorney in place. Or they had decisions about their care made by a Deputy appointed by the Court of Protection.

We found many staff had been employed a long time and that the nurses were competent and confident in initiating and documenting 'difficult decisions' around end of life care, resuscitation, withdrawals and the withholding of treatment. Staff told us that the organisation LOROS (a local charity that provides support to people and their families with life limited conditions)also provided support to people and their relatives.

We spoke with the registered manager about the implementation recording tools which stated people's preferred place of care and death. They told us they would look to implement these consistent with good practice.

Good

Is the service responsive?

Our findings

A person we spoke with told us "Staff answer my call bell quickly. I understand that there may be a short delay in assistance if they are with someone else, that is to be expected."

On the day of our inspection we spoke with a tissue viability nurse (TVN) who was there to see someone. They told us that the service via the person's general practitioner had requested their involvement to support a person and nursing staff with their treatment. The TVN told us they had spoken with the nurse and had made recommendations as to the person's care, which they were confident would be acted upon. They told us that the person involved was fully aware of their condition and the measures necessary to promote their health and wellbeing.

The service had a dedicated bedroom and equipment that enabled them to provide support for a bariatric patient. This meant the service could respond and provide a service when necessary.

One person told us that a physiotherapist visited them and assisted them to get up. They told us that prior to this they were not able to walk, but were now able to walk with the assistance of equipment.

One person told us that their dietician had advised them that they could taste small mouthfuls of food and that staff in response had gone of out of their way to provide them with a wide variety of different tastes.

We spoke with a physiotherapist who provided a service to many of the people at the service, where their services had been commissioned by health services or by the person or their representative themselves. They told us that the provider was pro-active in the care of people and that when they requested equipment necessary to improve people's well-being this was provided without hesitation.

A visitor told us that their relative had had to attend a range of hospital appointments and that the management team had ensured staff were available to accompany them. They told us that they had ensured the appropriate accessible transport was available.

People's needs, where they could not be expressed verbally were well documented, signed and dated and were supported by information that was specific to their needs and preferences. For example 'I prefer to have my teeth cleaned with a toothbrush, toothpaste and mouthwash. Having a fresh mouth is important to me.'

We received information from a health professional who commissioned the care of some people at the service. They told us that people themselves or their relatives were involved in reviews of care and were also involved in supporting people to attend health appointments. They also advised us the service had in their view prevented the need for people to be admitted to hospital which meant people had passed away peacefully at the service, which family members were grateful for.

Information within the provider information return stated that the nature and complexity of those using the service, meant pre-arranged courses of treatment were in place for a range of potential issues, such as a chest or urine infection. People's next of kin were aware of plans of care to deal with these issues and were signed by them. The provider also recorded that all issues of concern regarding people's health reported to them by a relative were acted upon quickly by nursing staff who carried out initial checks for signs of deterioration of health and took the appropriate action. We found that plans of care for pre-arranged courses of treatment were in place, which would enable the service to respond to people's changing needs in a timely manner.

The director told us that medication was kept on site that had been identified and prescribed by a doctor and would be administered when a person's health rapidly declined. Prescribed medication for the management of pain was also kept on site, this enabled nursing staff to respond to people's changing needs in a timely manner.

People's needs were initially assessed by a health care professional responsible for the commissioning of peoples' care. People's needs were in addition assessed by the director and registered manager to enable them to determine whether the service could provide the care a person required. Records showed where people were able to contribute to decisions about their care these were recorded and included in the person's plan of care. Where people did not have the ability to contribute peoples' relatives and significant others were involved.

One person said to us. "I would recommend more staff so they had the time to sit down and chat with me. No one

Good

Is the service responsive?

really takes the lead on activities but now one carer [activity organiser] spends an hour or so a week with me. I really enjoy this time, we play games such as Cluedo. I used to talk with a person who has now moved out of the home, I liked that. Now there isn't really anyone I can sit and talk with. I want someone to talk to but they say that there is no funding for it. I would be lost to death without my computer, I play games on it and I regularly go out with my family. Last August we had a garden party. My [relative] came but it was mainly staff."

An activity organiser had recently been employed to provide activities to people on an individual basis. One person we spoke with told us how they had been supported to undertake a planting activity. We also noted that people within their bedrooms listened to music or had the television on, and that the music listened to and the television programme watched was reflective of their wishes. For example some people watched and listened to programmes which reflected their cultural wishes which included watching and listening to Asian music and films. Bedrooms were equipped with a television, telephone and had internet access to enable people to maintain contact with family and friends.

People who used the service that we spoke with told us that they had no reason to complain and they wouldn't change anything. One person told us "I am confident to speak up for myself if I am not happy about something. I speak up for myself, I haven't really had to complain, except about the food. Staff are full aware and I don't mind you saying this."

The provider within the provider information return advised us that they had received one complaint within the last 12 months, which had been investigated and resolved by the director. A visitor told us they had raised concerns with regards to the food provided and that they had met with the registered manager to discuss their concerns. They told us that the food provided to their relative had improved and that they had no significant concerns about the care provided.

Good

Is the service well-led?

Our findings

A nurse told us that they believed standards in the home were high and that practice was constantly checked, updated and reviewed. They told us they were encouraged to ask for support rather than made to feel weak if they needed guidance.

Visitors told us that they were building a rapport with the staff at the service and that they were informed about changes to their relatives' health.

The service had a registered manager in post and there was a clear management structure. The director and registered manager demonstrated their enthusiasm and commitment to those who used the service. They had a comprehensive understanding of people's needs and they demonstrated how they worked with other agencies, this enabled people receiving a service to have their needs met.

We spoke with the nursing staff and care staff and all said they were supported by the management team. The director, general manager and registered manager told us they had an 'open door policy' which enabled staff to approach and speak with them about any issue.

We noted that the management team had a visible presence in the service and that they were available to people using the service, their visitors, visiting professionals and the staff employed. Discussions with the director and registered manager evidenced that they had a comprehensive understanding of the needs of people using the service and their families and had developed positive and caring relationships.

There was a system to support staff, through regular staff meetings, supervision and appraisal where staff had the opportunity to discuss their roles and the development of the service and the care of people. Supervision took the form of one to one meetings and competency assessments to ensure good practice for both nursing and care staff.

A member of care staff told us "I have a 121 (supervision) with my line manager every four to six months. I can discuss whatever I want and we discuss any training that is available. Not long ago we had a staff meeting. We discuss anything to do with the people who live here and any changes the directors are putting into place. If anything happens, lessons learnt are shared and reported back to us and retraining is given."

The training manager told us how they and the director arranged reflective sessions following significant events which occurred within the service, for example when a person died, when a person's health deteriorated and nursing staff had to intervene, or when a nursing procedure did not take place according to plan. They told us how these were used to develop and train staff and that this enabled all staff to reflect and improve on the care they provided and was used to revise and improve policies and procedures.

The management team had identified areas of responsibility within the service, which included the nursing care, the environment, staffing issues including recruitment and training, and catering and laundry services. Quality assurance audits were carried out to ensure systems within the service ran smoothly and where shortfalls were identified these were addressed by the relevant person.

Nursing staff, the chef and the physiotherapist told us that anything they required which was for the benefit of people who used the service was provided, and that the focus of the service was on delivering high quality care. The director and registered manager spoke to us about their vision and values of the service and said that the service was in place to provide good quality care, which reflected and achieved for people as normal a lifestyle as possible, given their medical condition, which was to be provided by staff who were caring.

We saw that relatives of people who use the service and health care professionals had completed questionnaires which sought their views of the service provided and we found them to be complimentary. The registered manager told us that where issues were identified within questionnaires these were dealt with on a one to one basis. However, we were told that the information had not been collated or used to produce a report and shared with people collectively**.** The entrance foyers provided information about the service, which included the services Statement of Purpose and questionnaires were displayed which provided an opportunity for people to comment on the service.

We saw there were systems in place for the maintenance of the building and equipment. This included maintenance of essential services, which included gas and electrical systems and appliances along with fire systems and equipment such as hoists.

Good

Is the service well-led?

The provider information return identified areas for improvement over the next 12 months, which they would introduce to enable them to continue to provide a good quality service. The provider identified this would be achieved by the provision of continued training in a range of areas. In addition the provider was looking to increase managerial training and qualifications and on going communication between all staff with a focus on lessons learnt and learning from others experiences to enable the service to continually improve.