Consensus Support Services Limited

Courtwick Park

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

Courtwick Park provides accommodation and support for a maximum of 10 adults with a learning disability or autistic spectrum needs. At the time of this inspection there were seven people living at the home. People had varied communication needs and abilities. Some people were able to express themselves verbally using one or two words; others used body language to communicate their needs. People required differing levels of support from staff based on their individual needs. Everyone required support and help to access the wider community outside of the home in which they lived.

This was an unannounced inspection which took place on 5 and 8 September 2017. The registered manager was given notice of the second date as we needed to spend time with her to discuss aspects of the inspection and to gather further information.

During the inspection the registered manager was present. 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.

We previously inspected the home in August 2015 when it was rated 'Good' overall and in all domains apart from the 'Effective' domain which rated 'Requires Improvement.' One breach of regulation was made due to a lack of Mental Capacity Assessments (MCA) and decision specific DoLS applications. At this inspection we found that steps had been taken by the registered manager and that the breach of regulation was met.

Quality assurance audits and checks were completed that helped ensure quality standards were maintained and legislation complied with. Quality assurance processes included obtaining and acting on the views of people in order that their views could be used to drive improvements at the home.

Staff were available for people when they needed support in the home and when they wanted to participate in activities outside of the home. Robust recruitment procedures were followed to ensure staff were safe to work with people.

People appeared happy and at ease in the presence of staff. Staff were aware of their responsibilities in relation to protecting people from harm and abuse.

Medicines were managed safely and staff training in this area included observations of their practice to ensure medicines were given appropriately and with consideration for the person concerned.

Checks on the environment and equipment had been completed to ensure it was safe for people to use.

People were supported to take control of their lives in a safe way. Risks were identified and managed that supported this. Systems were in place for responding to incidents and accidents that happened within the

home in order that actions were taken to reduce, where possible reoccurrence.

Staff were skilled and experienced to care and support people to have a good quality of life. Training was provided during induction and then on an on-going basis. Staff received support that enabled them to carry out their roles and responsibilities.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People were involved in the review of their care packages. People were supported to access healthcare services and to maintain good health. People had enough to eat and drink throughout the day.

Positive, caring relationships had been developed with people. Staff knew what people could do for themselves and areas where support was needed. Staff appeared dedicated and committed.

People received personalised care that was responsive to their needs. Activities were offered and people were supported to increase their daily living skills based on their individual abilities. People were also supported to maintain contact with people who were important to them.

Staff understood the importance of supporting people to raise concerns. Information of what to do in the event of needing to make a complaint was available to people.

People spoke highly of the registered manager. Staff were motivated and told us that management of the home was good. The registered manager was aware of the attitudes, values and behaviours of staff.

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.

Staffing levels met people's needs. Robust recruitment procedures were followed to ensure staff were safe to work with people.

Systems were in place that ensured that people received their medicines safely.

Risks were assessed and action taken where possible to reduce harm and to keep people safe. Staff knew how to recognise and report abuse correctly.

Is the service effective?

Good

The service was effective.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life.

People's right to consent where upheld. The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.

People were supported to eat balanced diets that promoted good health and their healthcare needs were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and positive, caring relationships had been developed.

Staff knew the needs of people and treated them with dignity and respect.

Systems were in place to involve people in making decisions about their care and treatment and people were supported to use these.

Is the service responsive?

Good

The service was responsive.

People received individualised care that was tailored to their needs.

Staff supported people to develop their daily living skills and to maintain relationships that were important to them.

People were listened to and their comments acted upon.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive culture which was open and inclusive.

Quality monitoring systems were being used to identify and take action to reduce risks to people and to monitor the quality of service they received.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

Courtwick Park

Detailed findings

Background to this inspection

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

Two inspectors and an expert by experience carried out this inspection which took place on 5 and 8 September 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the Provider Information Return (PIR) that the registered manager submitted. The PIR 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. We used all this information to decide which areas to focus on during our inspection.

The people who live at Courtwick Park used limited verbal communication. In order to ascertain if people were happy with the support they received we spent time with five people observing the care and support they received. This included how staff interacted with people and people's body language when they were going about their daily routines. We also observed a member of staff giving medicines to a person and we joined a person for lunch.

We spoke with registered manager, two team leaders, three care workers, a behavioural practitioner employed by the provider and an operations manager. We also reviewed information that we received from four external professionals who provided a service to people who live at Courtwick Park.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for three people, and other records relating to the

management of the home. These included three staff training, support and employment records, quality assurance audits and reports, minutes of meetings with people and staff, findings from questionnaires, menus, incident reports and maintenance records.

Good

Is the service safe?

Our findings

People said that they felt safe and we observed that they appeared very happy and at ease in the presence of staff. We did observe two occasions when one person appeared distressed when another person who lived at the home was near to them. Staff immediately offered reassurances to the person and as a result the person smiled. One external professional told us, "Although they did generate a lot of incidents and safeguarding's their responses to this were always very prompt and there request for additional support also quick. The manager knew that she had to try and stop these incidents and I believe was doing everything in her power that she could have done."

Information about abuse and ways to contact the local authority safeguarding team was on display and accessible to both staff and people who lived at the home. Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to protecting people from harm and abuse. They were able to describe the different types of abuse, what might indicate that abuse was taking place and the reporting procedures that should be followed. One member of staff said, "I would go straight to the manager and report it. I would write everything down and go higher to the area manager if needed."

Systems were in place for reviewing incidents and events in order that actions were taken to reduce, where possible reoccurrence. The registered manager completed a report of incidents and events that was reviewed by the provider's positive behaviour team and also shared with the providers clinical risk committee. This allowed the provider to retain oversight of events and for themes or trends to be identified. Prior to our inspection the registered manager had notified us and the local authority of assaults by one person on both staff and other people who lived at the home. Actions were taken to manage the person's needs and to ensure others were safe. These included input and advice from the local authority, the provider's positive behaviour intervention team, additional training and an increase in staffing for the person. In addition, detailed behaviour support plans and risk assessments were in place to help staff provide safe care. During our inspection a multi-disciplinary meeting took place to discuss the persons needs and it was agreed that despite the support given to the person the service could not meet the persons needs as these were impacting on others living at the home. Staffing levels had been increased in order to minimise any risks whilst the local authority supported the person to find more suitable accommodation.

Staff were able to explain how they supported people with specific needs and behaviours that could be viewed as challenging and the actions they took to ensure people were safe. One member of staff said, "It depends who is exhibiting behaviour and what this is. Generally we have to consider moving others from the person for their safety. We have to try and calm the person using distraction techniques to diminish the behaviour. We have to consider what might be causing the behaviour, could it be me? If so step back and ask for help. As a last resort and if the person is harming themselves or others we can use MAYBO techniques if trained to do so.' MAYBO are techniques which emphasis the least restrictive or non-physical intervention to keep people sale. The technique is accredited with the British Institute of Learning Disability (BILD). People's care plans included details of triggers when challenging behaviour may take place and when the safe use of any physical interventions should be used. These were recorded to a good standard and showed

people rights to ensure the least restrictive physical intervention were followed. We observed staff deal with two incidents where people's behaviour required staff intervention. These involved staff, working as a team or on their own, to supervise people during the incidents, using techniques to divert and calm people. These had positive results in calming people and keeping them and other people safe.

Other risks were managed in a safe way. Risk assessments and support plans were in place that considered any potential risks and strategies were in place to minimize the risk. For example, one person had padding next to and on the corners of their bed in order to reduce the risk of injury and soft floor covering again to reduce the risk of injury if they were to fall.

Checks on the environment and equipment had been completed to ensure it was safe for people. These included the fire alarm, emergency lighting and extinguishers. There was an up to date business continuity plan in place that assessed and planned for events that included adverse weather conditions, fire and power outage. Personal Emergency Evacuation Plans (PEEPS) were in place for individuals that could be used to move people safely in the event of a fire.

Appropriate arrangements were in place in relation to the recording, storage and administration of medicine. In addition to medicine administration records (MAR) people had individual medicine profiles which included a photograph of the individual, details of what each medicine was for and guidelines for 'as and when required' medicines. There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. The recording and storage of medicines and training of staff was in line with the provider's medicines policy. The staff responsible for administering people's medicines were trained and competency assessments were in place that included observations of their practice. We observed a member of staff giving people their medicines and saw that they did this safely. They checked the information on the MAR corresponded with that on the medicines label before giving medicines to people. They did not sign the MAR to confirm people had taken their medicines until they had observed them doing this.

We observed that there were sufficient staff on duty to meet people's needs safely. Staff were available for people when they needed support in the home and in the community. Staff told us that they had enough time to support people in a safe and timely way. When shifts needed to be covered due to vacancies or leave the registered manager tried to use staff employed by the provider at nearby services for consistency. Staff confirmed this approach helped people who had specific behavioural needs. One member of staff explained how they worked at an activity centre operated by the provider which one person who lived at the home used to attend. The member of staff told us they had "Got to know (person's name) from when they attended and they remember me so it helps."

Staffing levels were based on people's needs. Dependency levels were assessed and agreed with the relevant local authority who funded people's placements and staffing allocated according to their individual needs. Six people were funded one to one care hours which the registered manager explained were used on different days and times. For example when activities outside of the home required. The registered manager said, "I try and keep rotas flexible as I can." Records that we looked at confirmed this. One person had been receiving increased staff support in order to meet their needs and another's one to one support had been reduced as the registered manager had identified these were not needed.

Staff recruitment records contained information that demonstrated that the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant

documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home.

Good

Is the service effective?

Our findings

At our previous inspection a requirement action was set for a breach of regulation 13 as DoLS applications were not personalised or decision specific. In response, the provider sent us an action plan that detailed the steps that would be taken to address this. At this inspection we found that sufficient steps had been taken and that the requirement action was met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Since our last inspection the registered manager had taken steps to manage restrictions on people's freedom. The registered manager had submitted DoLS applications to the authorising authority for people who lacked capacity, were unable to leave the home freely and were under constant supervision. As part of this process a mental capacity assessment had been completed which considered what decisions the person had the capacity to make. There was also evidence of 'best interest decisions' having been made involving representatives of the person and other professionals involved in their care. Sensors were used for some people to alert staff if they had a seizure whilst in their room and another person had a sensor fitted to their bedroom door that alerted staff of their movements. DoLS applications had also been submitted for these and in some instances had been authorised. The registered manager maintained a record of contact she made with the authorising authorities for those that were still waiting authorisation and regularly reviewed the progress of these to ensure people's rights were promoted.

We observed that staff checked that people were happy with support being provided on a regular basis. When one person spilt a drink on themselves a member of staff asked the person if they would like support to go and change. The person indicated that they would and was supported accordingly. Throughout our inspection we observed that staff sought peoples consent and used both verbal and non-verbal forms of communication in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

Staff were skilled and experienced to care and support people to have a good quality of life. All new staff enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers should apply in their daily working life. It is the new minimum standard that should be covered as part of induction training of new care workers. Staff confirmed that during their induction they had read people's care records, shadowed other staff and spent time with people before working independently. They also said that they had regular meetings with the registered manager or senior member of staff who reviewed their progress and offered support. Training was provided during induction and then on an on-going basis. Staff were trained in areas that included first aid, fire safety, food hygiene, infection control, equality and

diversity, medication and moving and handling.

A training programme was in place that included courses that were relevant to the needs of people who lived at Courtwick Park. These included positive interventions, least restrictive interventions, epilepsy, diabetes and autism. Some staff had also received Makaton awareness. This meant that staff were provided with training that enabled them to support people appropriately.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. All staff that we spoke with said that they were fully supported to undertake their roles. One member of staff said, "I feel supported. We are a good team here and supported by the manager and seniors. We get regular supervision." A second member of staff said, "This manager gives us opportunities to learn. She is very good at encouraging us. She puts us on training and pushes us to do our NVQ."

People played an active role in planning their meals and had enough to eat and drink throughout the day. People who were unable to communicate verbally were supported to make choices by using picture cards depicting different meals with choices then planned for and provided on the weekly menu planner. Staff demonstrated understanding of supporting individuals to have meals of their choosing. When supporting one person at lunch time a member of staff gave the person a choice of two different sauces with the person then choosing one. Whilst putting the sauce away the person went to the bin and tipped their meal away. The member of staff calmly said, "So I take it that you do not want that. Would you like to choose something different?" The person was then offered an alternative and asked if they would like to help prepare this to which they indicated they would. Both the member of staff and the person then went and prepared the second meal before the person sat and ate.

People were supported to receive a balanced diet that promoted healthy eating. Staff knew people's individual preferences without the need to refer to their records. In relation to one person who lived at the home a member of staff said, "His diet is soft mashable foods. Can still have the things he likes but we have to make sure they are soft." Where necessary Speech and Language Therapists (SALT) had assessed people's needs and support plans and assessments incorporated their recommendations. People's likes and dislikes as well as information on whether they had specific needs were also recorded. This enabled the home to provide people with food they liked and for those who could not tell them verbally what they wanted, with food they were known to enjoy. Although people were not able to tell us specifically if they liked the food we observed a person become animated when they were informed what was for lunch. When the person was presented with the lunch they appeared to enjoy it, indicated they would like a second serving and this was provided.

People were supported to access a range of healthcare services and to maintain good health. One external professional informed us, "They were always good at getting proper medical support and requesting support from the local CLDT such as psychology and O.T." Records confirmed that people had access to GP's, chiropodists, dentists, psychologists, behaviour support teams and other healthcare professionals. When recommendations were made these were acted upon. People had hospital passports which provided hospital staff with important information about their health if they were admitted to hospital. They also had health action plans in place which supported them to stay healthy and described help they could get. Disability Distress Assessment Tool (DisDAT) had been completed for people which helped staff identify if the person might be in pain or discomfort and require medical attention. This tool was designed to help identify distress in people who have severe limited communication.

Good

Is the service caring?

Our findings

Positive, caring relationships have been developed with people. One external professional told us, "I met with many staff there and they all had a clear warmth towards there customer's and when I attended an annual review it was one of the most person centred reviews I have been to with pictorial storyboards set up which evidenced his activities and goals." A second external professional said, "From what I have witnessed, the staff are very approachable, caring and willing to oblige. I have found the atmosphere to be balanced with the staff trying to maintain a sense of equilibrium in sometimes difficult conditions."

Staff were observed providing positive engagement and appropriate support to people. We observed staff interacting in personalised ways with people. When interacting with people staff always met the person at their level. If the person was sitting they would either sit next to them or crouch down. If the person was lying on the floor, the staff would kneel. One staff member told us how a person enjoyed staff singing particular songs to them. We heard this happening during the inspection. Both staff and people who lived at the home had one page profiles completed which contained information about their personalities, likes and interests. The registered manager told us that they used this information to match staff to people with shared interests where possible. Interests and hobbies were also explored when potential new staff were being interviewed in order that staff were employed with the similar likes and interests.

The religious beliefs of people were respected and promoted. The registered manager and staff were able to tell us about the religious beliefs of a person living at the home and the support they provided to maintain these. These included not having their hair cut and watching television. We observed and records confirmed these were respected.

People were supported to maintain relationships with people who were important to them. Staff were able to describe people's individual choices and what aspects of a person's life was important to them, including family relationships. Staff had supported two people to attend surprise birthday parties for their family members. We were shown photographs of one of the family gatherings. Other people were supported to have contact with their families either in person or by telephone.

People were supported to be involved and to make decisions about their care. Each person was allocated a key worker and those we spoke with were able to tell us in detail about the person's preferences and what they enjoyed. We were shown a flipchart in the registered manager's office which demonstrated how one individual was engaged and involved in their review of care with commissioners and their key worker. Photographs indicated that the person was able to make their own choices regarding personal preferences and we saw evidence of them pointing to specific interests and preferences. We saw how this person had chosen their preference of a double bed rather than a single bed to sleep in. arrangements had been made for the same person to receive additional support from an external advocate to ensure they received further support to be involved in decisions relating to the support they received.

People's privacy and dignity was promoted. When a person, who was lying on a sofa in a communal lounge began to lift their top a member of staff calmly and quietly said, "Shall we cover that up?" and helped the

person to lower their top and preserve their dignity. People's individual records were stored securely. People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. Good attention had been given to people's appearance and their personal hygiene needs had been supported. Objects of reference were used to involve people in making decisions about their personal appearance. For example we observed a member of staff give one person a shoe. The person then chose which footwear to put on.

There were policies and procedures in place for respect and dignity which were discussed with staff during their induction. Staff practice in these areas was then monitored informally on a daily basis by the registered manager and formally during the monthly audits that were completed. Staff demonstrated understanding of treating people with dignity and respect. One member of staff said, "They are all individual people with individual needs." The member of staff was able to explain the individual needs of people in detail without referring to records. This included people's preferences, health needs, dietary requirements, family and history.

Good

Is the service responsive?

Our findings

People received a responsive service based on their individual needs and preferences. One external professional told us, "The manager always came across as someone who is very "on it". And when I was the allocated worker for a number of the customers there she would be very responsive and proactive of informing me and seemed to have a very good understanding of her customers and her role there." A second external professional told us, "My belief is that the service wants to work hard, the manager is responsive and communicates very well with the local authority. I believe the manager has a good understanding of the residents and is always well informed at meetings. I believe that care staff are generally caring and well-meaning towards the residents and again, they are knowledgeable about residents when discussed with them."

Staff responded appropriately to ensure a person with epilepsy received responsive support. Assessments and care plans were in place that helped staff provide responsive care. Staff were able to explain the support the person should receive if they had a seizure. One member of staff said, "They wear a helmet as they fall when having a seizure so this reduces them injuring them self. If they have a seizure we have to go to them asap. Talk to them and reassure them. Move any objects that might be near them. Hold their hand and also time the seizure. If it goes on more than seven minutes we give medicine but it's been a long time since we have had to do that." Records confirmed that the person had not experienced a seizure that had required the medicine that the member of staff referred to for over a year and that healthcare professionals involved with the persons care were happy with the support given by staff at the home.

When the physical needs of another person changed responsive action was taken to ensure appropriate support was provided. This included a referral to a physiotherapist and wheelchair services. A hand rail had been fitted to assist the person to move from one room to another in response to the changes in their needs. The homes vehicle had also been changed to a wheelchair accessible one in response to the person's needs. The registered manager had also arranged for an occupational therapist to conduct an assessment in order to see if they could improve engagement in activities and social interaction. As a result of this a number of recommendations were made which we saw were put into place during our inspection. This included tactile activities such as foot yoga and hand massages. When these were being provided we observed that the person became more alert and responsive to their surroundings. The member of staff set up the lounge with softly flashing lights and calm music. Communication was appropriate for the occasion and the member of staff checked throughout the session if the person was enjoying the event.

Action was taken to provide sensory stimulation for another person who lived at the home. Staff had attended a workshop with the behaviour support team and the use of strong flavoured foods were explored and the use of weighted clothing and external stimulation. As a result, a weighted jacket was provided when the person was supported to take long walks in the surrounding areas and specific foods were identified that stimulated positive reactions from the person.

A quiet lounge was in the process of being redecorated but one person still chose to use this facility. Due to behavioural issues when supported to access the gym in a centre located in the grounds of the home staff

had brought an exercise bike over to the house and set it up in the quiet lounge so the person could still access this activity.

People had individual activity timetables that were used as a basis for planning activities and events. Staff told us that a favourite activity of people was going out for something to eat. They informed us and records confirmed that everyone had the opportunity to go out twice a week for either lunch or dinner.

People were supported to increase their daily living skills based on their individual capabilities. People had contributed to decorating a shared communal area. Photographs evidenced people's participation with painting one of the walls with staff support using hand over hand techniques. On the day of inspection we also observed two people who were supported by staff to access the kitchen and engage in daily living tasks that included preparing a meal.

People's support plans were person centred and included details about the emotional and communication support people required. Staff understood that people's communication needs varied. They were able to tell us about the individual needs of people. Records included information about people's social backgrounds and relationships important to them. They also included people's individual characteristics, likes and dislikes, places and activities they valued. We observed that staff supported people in line with their wishes and the contents of their support plans. Efforts were made to involve people and those who were important to them in the reviewing of their care plans and in making decisions. The registered manager produced a booklet which she sent to families every three or four months that included photographs and details of people's key workers so that relatives had a named person to contact if needed.

Peoples care records and information in the home was provided in large print, with the use of photographs and pictures which helped people to understand and to communicate. This was in line with the Accessible Information Standard. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People were routinely listened to and their comments acted upon. Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. Staff assessed if people were happy as part of the everyday routines that were taking place.

Pictorial information of what to do in the event of needing to make a complaint was displayed in the home. For people who could not access written or pictorial procedures staff told us that they observed their interactions and body language and would report any concerns to the registered manager. Two complaints had been received in the previous 12 months. Records showed that these had been acted upon in line with the provider's procedure.

Good

Is the service well-led?

Our findings

The provider had clear values that placed people at the heart of service provision. These included 'Choice and respect' 'Honesty and integrity' and 'Inclusive and supportive.' We found that these values were owned by the registered manager and staff and embedded in practice at the home. There was a positive culture within the home which promoted honesty, openness and an application of human rights, diversity and equality during care delivery. As a result, people received an individualised service from a dedicated and committed staff team. One staff member said that the staff worked really well as a team and that the staff team were "One big family." A second member of staff said, "I absolutely adore the people I support." A representative of the provider had recently completed a care shift at the service. This allowed senior management to gain insight into living at the home and for staff working there. It also was an opportunity for staff to speak directly to senior management.

Staff were motivated and told us that they were supported by the registered manager to understand their roles and responsibilities. They told us that the registered manager led by example and regularly thanked them for the work they did. One member of staff said, "Considering this is her first management job her general attitude to everything is good. She is a strong leader." A second member of staff said, "They have just brought in vouchers for extended service. The manager does employee of the month where someone gets flowers or a small gift and a thank you card. I got one. It was really nice and it made me cry."

The registered manager demonstrated an open and honest demeanour. When we brought to her attention a shower chair of poor quality she was apologetic and immediately ordered a new one. This demonstrated openness in line with Duty of Candour. Duty of Candour places a requirement on providers to inform people of their rights to receive a written apology and truthful information when things go wrong with their care and treatment.

The registered manager demonstrated knowledge and understanding of her legal responsibilities to ensure compliance with the regulations. She was able to explain when and how to report allegations to the local authority and to the CQC. The registered manager submitted statutory notifications to us in line with her legal responsibilities. Information about the regulations and an abundance of guidance was on display in the registered manager's office. The registered manager had displayed this on noticeboards under the headings of 'Safe, Effective, Caring, Responsive and Well led.' Staff confirmed that this information was discussed with them on a regular basis in monthly staff meetings and supervision. They confirmed that the information helped them provide effective support to people and to understand their roles and responsibilities.

There were clear whistle blowing procedures in place that were discussed with staff during induction and supervision. Staff were able to explain what these were when asked. They understood how the whistleblowing procedures offered protection to people so that they could raise concerns anonymously. The provider had sourced an independent company who operated a 24 hour confidential telephone line for staff to discuss any concerns.

A range of quality assurance audits were completed by the registered manager and representatives of the provider that helped ensure quality standards were maintained and legislation complied with. Monthly and annual audits covered areas that included medicines, care planning and staff support. Audits also included representatives of the provider visiting the home meeting people, staff and the registered manager. Where shortfalls were identified, action plans were put in place and steps taken to take action promptly. As a result of medicine audits the process of checking stock of medicines that are not supplied in a monitored dosage system had been reviewed and improved. Records did not evidence that people participated in activities on a regular basis or in line with the contents of their support plans and preferences. A lack detail regarding activities and the provision of in-house activities was identified by a representative of the provider who conducted an audit in June 2017. An action plan was in place to address.

People's views were also obtained and used to drive improvements in the form of annual questionnaires. These had been sent to people in July 2017 and were in the process of being collated. The previous year's findings rated the service 'good' or 'very good' in all areas apart from the environment which some people rated as 'satisfactory' or 'poor.' The registered manager informed us that the bathrooms were going to be refurbished as part of a refurbishment and review of the whole service. It had been recognised that accessibility to some areas of the building for some people who lived there was affected as they aged and their needs changed. The review included ensuite bathing facilities and the possibility of installing a lift. We received written confirmation that the proposals for the changes to the building were with the provider and that discussions with local commissioners on providing a service that would meet the long term needs of people were taking place. It was the view of two external social care professionals that the environment also affected the ability to manage aspects of a person's behaviours. We were informed that it was hoped that a decision would be reached in the next couple of months regarding the building.