HF Trust Limited

H F Trust - Keilder House

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 30 and 31 March 2015 and was unannounced. This was our first inspection of this service, at this location. We last inspected this service at a different location in September 2013 and found no breaches of legal requirements at that time.

H F Trust - Keilder House provides personal care and accommodation for up to ten people living with a range, and combination, of physical disabilities, learning disabilities, dementia and Downs syndrome. At the time of our inspection seven people were in receipt of care from the service.

At the time of our inspection a registered manager had been in post and registered with the Care Quality Commission since July 2014. A registered manager is a person who has registered with the Commission to manage the service. Like registered providers, they are

Summary of findings

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

People who lived at the service were unable to communicate with us verbally due to the nature of their conditions. There were systems in place to protect people from abuse and channels through which staff could raise concerns. Records showed, and the registered manager confirmed that no safeguarding matters had arisen within the 12 months prior to our inspection. Historically, safeguarding incidents had been handled appropriately and referred on to the local authority safeguarding team for investigation.

A process was in place to assess people's needs and the risks they were exposed to in their daily lives. Regular health and safety checks were carried out on the premises and on equipment used during care delivery. Care records were regularly reviewed and medicines were managed and administered safely.

Recruitment processes were thorough and included checks to ensure that staff employed were of good character, appropriately skilled, and physically and mentally fit. Staffing levels were determined by people's needs. Staff records showed they received regular training and that training was up to date. Supervisions and appraisals for staff were conducted regularly and staff confirmed they could feedback their views during staff meetings or their individual sessions with their manager.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act (2005). These safeguards exist to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the registered manager had applied for DoLS for people living at the home. In addition, people's ability to make informed decisions had been assessed, and the 'best interest decision making process applied correctly. These decisions were well documented and information about people's ability to consent and their capacity levels were clear within their care records.

People's general healthcare needs were met. A range of healthcare professionals were regularly involved in people's care due to the nature of their conditions and staff did not hesitate to contact these professionals where there were concerns about their health or welfare. People's nutritional needs were considered and specialist advice was sought and implemented where necessary, for example from the speech and language therapy team (SALT).

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people. People had individualised care plans and risk assessments which were reviewed regularly. Staff were aware of people's individual needs. People's individuality and diversity was taken into account. People had good access to their local community and we saw that two people enjoyed trips out during our inspection.

Healthcare professionals linked to the service spoke highly of the registered manager and the positive leadership that she delivered. Systems were in place to monitor care delivery and ensure that people received safe and good care. Audits were done regularly and any identified issues that needed to be addressed were formulated into action plans so they could be resolved.

The organisation had electronic monitoring systems in place to guide staff and direct them on who to notify when certain incidents occurred. A new electronic system was being introduced to record people's personal information and care needs. The provider looked for ways to innovate, in order to gain the best possible overview of the service and care delivered.

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 appeared comfortable in the presence of staff. There were procedures in place for referring matters of a safeguarding nature to the local authority for investigation. The registered manager and staff had a good understanding of safeguarding vulnerable adults.

Staff skills and their suitability to work at the home had been checked before they commenced employment and relevant health and safety checks on the premises and equipment used in care delivery had been carried out regularly.

Staffing levels were sufficient to safely meet people's needs and medicines were managed safely.

Is the service effective?

Good

The service was effective

People received individualised care that was effective in meeting their needs. Staff were skilled, experienced and supported by management to maintain their skills. They received regular supervisions and appraisals.

People's nutritional needs had been assessed and they were supported to eat and drink safely and in sufficient amounts. People had input into their care from external healthcare professionals, as and when necessary.

The Mental Capacity Act (2005) had been appropriately applied and the best interest decision making process followed to ensure decisions about people's care were made collectively by more than one person. Applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

Is the service caring?

Good

The service was caring

Staff displayed caring and compassionate attitudes when delivering care.

People were given choices wherever possible and a relative we talked with spoke highly of the staff team.

People were treated with dignity and respect and their privacy was promoted.

Some people had relatives advocating on their behalf, but the registered manager told us that if this was not possible and an advocate was needed, there were systems in place to arrange this.

Is the service responsive?

Good

The service was responsive

Where necessary staff requested support from external healthcare professionals to address concerns.

People's care records were individualised and person-centred. They were reviewed regularly, and where necessary, updated in light of changes in people's care needs.

Summary of findings

Complaints about the service were rare and the manager told us there had not been a complaint received by the service in the past 12 months. People's relatives and staff were given the opportunity to feedback their views about the service via the registered manager directly, in meetings or via the completion of surveys.

Is the service well-led?

Good

The service was well-led

A relative and external healthcare professionals spoke highly of the registered manager with whom they said they enjoyed a positive working relationship.

The registered manager had systems in place to monitor care delivery and ensure that people received safe and received good care. Audits were done regularly and any identified issues that needed to be addressed were formulated into action plans so they could be resolved.

The organisation had electronic monitoring systems in place to guide staff and direct them on which external organisations to notify when certain incidents occurred. A new electronic system was being introduced to record people's personal information and care needs.

H F Trust - Keilder House

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 30 and 31 March 2015 and was unannounced. The inspection team consisted of one inspector.

Prior to this inspection we reviewed all of the information we held within our own records at the Commission (CQC) about the service. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of, in line with the requirements of the CQC Registration Regulations 2009. We also reviewed any information that we had received from third parties. We contacted the local authority commissioners of the service and the local authority safeguarding team. The information they provided was incorporated into the planning of this inspection.

None of the people who lived at the service were able to converse with us verbally. Therefore we carried out observations of the care and support that they received, to help us understand their experiences. We spoke with five members of staff and the registered manager and we walked around the care home and looked in people's bedrooms. We reviewed a range of records related to people's care and the management of the service. This included looking at three people's care records, six staff files (including recruitment, induction and training records), all seven people's Medication Administration Record sheets (MARs). We reviewed records related to quality assurance and the maintenance of the care home building and equipment used within the home. Following the inspection we attempted to contact several people's relatives to gather their views of the standard of service that people received but were only able to speak with one relative.

Good

Is the service safe?

Our findings

We spoke with one person's relative following our visit to obtain their opinion of the service. They told us, "I think the service is great; there are no worries". One healthcare professional told us, "They look at minimising risks. They looked at one person falling and thought about changing the position of their chair in the room to prevent this".

We observed staff whilst they delivered care and supported people. They adopted moving and handling procedures that were both appropriate and safe and we had no concerns about people's safety or how they were treated by staff.

We spoke with both the registered manager and staff about safeguarding and whistleblowing. They were able to tell us about what constituted abuse and the procedures they would follow if they had any concerns that people were at risk or they had witnessed abuse. Each member of staff we spoke with was aware of their own personal responsibility to report incidents of this nature. The registered manager confirmed that there was one on-going safeguarding case at the time of our inspection. Records showed that historic safeguarding cases had been dealt with appropriately and referred to the relevant local authority for investigation in line with protocols.

The registered manager kept records of accidents and incidents that occurred within the service and these were monitored to ensure that an any issues arising were addressed and plans put in place to prevent repeat events. One person who had fallen several times recently had been referred to an occupational therapist (OT) for input into their care to ensure that they remained as safe as possible, without restricting their independent movement. The person's care records showed that staff were observing this person on the advice of the OT and recording their observations. Accident records detailed the nature of the accident or incident and the actions the manager had taken in response to these. For example, there had been some minor medication errors in recent months. Whilst none of these errors had any impact on people's safety or wellbeing, the manager had ensured that best practice guidance around the safe management of medicines was reiterated to staff verbally. All staff had been sent on refresher medication training and had their competency to administer medication assessed.

Medicines were managed appropriately and safely. Where there had been medication errors, these had been handled promptly and effectively by the registered manager, with support as necessary from the regional manager of the service. The administration of medicines involved two people, one who administered and one who witnessed the administration. Both staff members signed the medication administration record (MAR) to confirm their involvement in the process. We checked each person's MARs and a cross sample of medicines against these records and found that they were all complete and up to date.

Staff were very knowledgeable about how to support people with their medicines and the management of medicines within the service was person centred. Medicines that needed to be administered before food or those which were prescribed for use on an 'as and when required' basis (PRN medicines) were highlighted on people's MARs. Staff confirmed that they organised the order in which they administered medicines to account for a suitable time lapse before or after food, where people required this. They were clear about when they would use PRN medicines for specific individuals, and explained there was personalised individual guidance available for them to refer to. The ordering, storage, handling, recording, administration and disposal of medicines was safe and well managed.

We reviewed people's care records and found that risks which people were exposed to in their daily lives had been assessed. Written instructions were in place for staff to follow about how to manage and reduce these risks. Where relevant, there were assessments related to nutrition and

choking risks. Speech and language teams (SALT) were involved in people's care and had drafted specific care plans and risk assessments for staff to follow. There was also evidence of care reviews taking place involving multidisciplinary teams of healthcare professionals. They reviewed risks associated with people's care and they provided input on how to deliver safe care.

We looked at the management of environmental risks within the building and found that regular fire and health and safety checks were carried out and documented. People had personal evacuation plans in place and in each person's bedroom there was an evacuation mat for use in a fire, to aid staff to move people to a place of safety. Equipment was serviced and maintained regularly and safety checks were carried out on, for example, electrical

Good

Is the service safe?

equipment, the electrical installation within the building, and gas supplied equipment. The risks associated with the development of legionella bacteria within the home had been assessed and there were effective controls measures in place to prevent it developing, such as checking water temperatures and decontaminating shower heads. Regular temperature checks were carried out on the fridge and freezer to ensure that food was stored safely and people were not at risk. In addition, the temperature of food was checked before it was served to ensure it was within safe and recommended limits. This showed that the provider sought to protect people from harm and promote their health and safety.

Staff files showed that recruitment procedures were thorough and staff were vetted appropriately before they started working at the service. Application forms were completed, including previous employment history. Staff were interviewed, their identification checked, references sought from previous employers and Disclosure and Barring Service (DBS) checks obtained before they began work. Records showed new staff members had completed a health questionnaire prior to starting work. This meant the registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

Staff told us staffing levels were sufficient to meet people's needs and our observations confirmed this. The registered manager told us any shortfalls in staffing, for example due to sickness or annual leave, were covered internally by other members of the staff team. This meant that wherever possible, people were supported by staff who they were familiar with and who knew their needs well.

Good

Is the service effective?

Our findings

The relative we contacted spoke highly of the service and the staff team. They said, "I think it is very good. The care is excellent. All of the staff there seem to understand the needs of the people they support".

We spoke with four healthcare professionals linked with the service to establish their views about the effectiveness of the service. They spoke highly of the staff team and the level of care and support that they saw delivered. One healthcare professional commented, "They have specialist skills in dealing with people. I think they do really well there and I have no worries about this home. We have regular multidisciplinary team meetings and all members are involved in best interest decision making". Another healthcare professional told us, "Staff work well to implement the programmes and care that is put in place. They take necessary action and look at minimising risks. They are really good at facilitating a multi disciplinary team approach to people's care". A third healthcare professional told us, "This is a specialist unit caring for people with highly complex needs and the staff are very dedicated and able. They are very receptive and they follow healthcare recommendations that we give them".

Staff gave us detailed information about the needs of the people that they cared for which tallied with our own observations and the information written in people's care records. They were able to tell us how they had learned to read people's facial expressions, noises they made, or changes in behaviours, to establish their mood and whether or not they were happy with a particular action or personal care task.

Staff were able to tell us about the physical signs people displayed which would indicate that they were in pain and discomfort (and therefore when they may need PRN medicine). For example, staff told us that one person would bend over when in pain, another would raise their hand to their head if they had a headache, and a third person would display discomfort and pain via their facial expressions. Information about this was recorded in people's care records and where relevant, specialist nursing staff from within the community healthcare setting had written specific care plans around pain management. Staff displayed an in-depth knowledge of people and their needs, which we saw they used to provide effective, personalised care. They interpreted people's needs and communicated with them effectively in a way that enabled them to carry out their role and responsibilities.

The service supported people appropriately to meet their nutritional needs. Staff told us there were no set mealtimes as people tended to have varied sleeping and eating patterns. There was a rotational two week menu in place, but staff said that if people refused the meal that had been prepared, something else that they knew they liked would be made for them. The majority of people living at the home had some form of dietary requirement and staff were knowledgeable about each of these requirements. For example, they told us that one person had a gluten-free diet and another person was on a healthy eating plan introduced by their dietician. We observed the lunchtime meal and saw that where people needed food or drink of a certain thickness or consistency they received this. Staff patiently supported people to eat and drink. Food and fluid charts were in place to monitor people's nutritional intake, in light of the varying times throughout the day and night at which they may consume food or drink. People were weighed regularly to ensure that any significant fluctuations in their weight were identified and where necessary, referred to external healthcare professionals for advice and input.

People's general healthcare needs were met and there was a multi-disciplinary approach to people's care with a view to promoting their health and well-being as much as possible. There was evidence that referrals were made promptly to external healthcare professionals and services where people's needs changed. One person was ill on the day of our visit and staff responded by contacting the person's doctor for advice. A home visit was then arranged for this person as soon as practicable. This showed that the staff team and the registered manager ensured people's general healthcare needs were met and they remained as healthy as possible.

A relative told us that they were informed about their family member's health and any treatment options. People were supported to attend routine appointments, for example, at the opticians to check their eyesight. In addition, people had input into their care from healthcare professionals such as doctors, occupational therapists, speech and language therapists and psychiatrists whenever necessary.

Good

Is the service effective?

Information in people's care records demonstrated that consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the Mental Capacity Act 2005 (MCA). The registered manager told us that Deprivation of Liberty Safeguards (DoLS) were in place for all people who lived at the home. DoLS are part of the MCA 2005. They are a legal process which is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. These applications and decisions are made in people's best interests by the relevant local authority supervising body.

There were many examples of best interest decisions taking place about people's care in line with the MCA. This was confirmed by people's relatives and healthcare professionals working with the service who informed us that decisions were always made by a multi disciplinary team and family (if applicable) in line with the best interest decision making process. Documentary evidence of this existed in people's care records and was well maintained to evidence that the registered manager and provider understood their legal obligations under this act.

Staff told us they felt equipped with the skills they needed to fulfil their roles and their training was up to date. They told us they felt supported by the registered manager and that they were able to maintain their skills by refreshing training as and when required. An induction programme for new staff was in place. Records showed that staff had received training in key areas such as moving and handling, infection control and safeguarding. A training matrix was in place which was managed by staff at the provider's head office, to help track when individual staff members training needed to be repeated. Staff had also received specialist training in areas relevant to the needs of the people they supported. For example, staff were trained in Percutaneous Endoscopic Gastrostomy (PEG) feeding tubes, which are used for people who cannot take food by mouth.

Staff told us and records confirmed they received regular supervision and appraisal. They said they felt supported by the registered manager who was very approachable. We saw that supervisions and appraisals were used as a two-way feedback tool through which the registered manager and individual staff could discuss work related issues, training needs and personal matters if necessary.

Good

Is the service caring?

Our findings

People appeared content and looked well cared for. One relative commented, “I think it is first class. Staff are very well in tune with people”.

We observed care delivery and watched how staff interacted with people. We saw many pleasant interactions when staff were supporting people, for example when assisting them with meals or moving and handling. Staff engaged with people compassionately, politely and respectfully, and there was a calm, happy atmosphere within the home. One staff member assisting a person with lunch was gentle and patient in their approach. They held the person’s hand at times for reassurance and encouraged them to eat, taking time between offering mouthfuls of food, so that they were not rushed.

Staff included people in their care. Whilst people could not converse with staff, we saw staff talked them through each of the different stages of care delivery. This meant people were kept informed and could indicate their agreement or disagreement. For example, staff told one person that they were going to reposition them in their wheelchair to a different part of the room, in advance of moving them.

Staff delivered care which promoted and protected people’s dignity and privacy. For example, staff discreetly transferred people to their bedrooms to deliver personal care, administer medication and for one person, administer food through their PEG tube. People’s bedroom doors were closed when staff delivered personal care which showed they understood the importance of promoting people’s privacy and dignity when supporting them. We saw they encouraged one person who could weight bare to mobilise themselves and therefore to remain as independent as possible, despite them having difficulties with mobility. At the same time, they ensured the person remained safe.

People’s diverse needs were considered. For example, one person was supported to attend their local church on a Sunday morning each week and arrangements were being made for a person who was new to the service, to have a weekly visit at the home from their vicar. Staff had completed training in equality and diversity which showed the service promoted this.

One relative told us they felt fully involved in their family member’s care and they were kept informed about changes in their care. Care plans reflected people’s life histories and staff were knowledgeable about people’s likes, dislikes and the activities they liked to pursue.

At the time of our inspection no people living at the home had a formal advocate in place although the registered manager told us that sometimes people’s family members advocated on their behalf. The registered manager told us she had good links with people’s care managers and would contact them to arrange an advocate if necessary.

Good

Is the service responsive?

Our findings

One person's relative told us they felt involved in their relation's care and the service was responsive to changes in people's needs. They commented, "I am involved. X (registered manager) calls me if there is anything wrong". Healthcare professionals told us that the registered manager and staff were proactive in ensuring people got the care and support they needed and they referred matters of concern as soon as possible to the relevant parties. One healthcare professional told us, "X (registered manager) and the team are very good at getting the right people involved". Another healthcare professional who worked closely with the service said, "The team are very receptive to the multi-disciplinary team input into people's care. They are good to work with. Things are discussed well and everyone is involved".

Care delivery was person-centred. It was clear from our observations that staff knew people very well. They told us that they gave people who could not communicate verbally as much choice as possible in relation to day to day decisions and our observations confirmed this. Staff said they could read when people were happy or when they were not, and what they liked and disliked, via how they expressed their emotions and particular expressions and behaviours they adopted.

A keyworker system was in operation where individual staff members were responsible for overseeing particular people's care needs were met, regularly reviewed and their care records updated. Staff told us that all relevant parties were kept informed as and when needed, in respect of any changes in people's care needs.

Care records were comprehensive and informative. They were well structured and well maintained. They were individualised and contained guidance for staff to follow about people's needs and safe ways to deliver care. There were care plans for each of the person's assessed needs such as mobility and personal hygiene. There was detailed information about how to communicate with people which was very important based on the needs of the people who lived at the home. Where relevant, a disability distress assessment tool was present in people's care records which gave staff information about the facial signs, jaw movements, sounds, habits, mannerisms and appearance of people's eyes and skin, when they were distressed. There was also information available to staff about people's habits when they were content. One person's care records detailed a list of triggers and de-escalation techniques to be attempted before the administration of medicine for anxiety. This meant that staff were equipped with the necessary information to enable them to deliver personalised care of a good and safe standard.

There was evidence that initial assessments took place before people received care and regular systematic reviews and evaluations followed to ensure that people's care remained appropriate, safe and up to date. Each person had a 'hospital passport' in place which could be easily located in the medication room in the event of a hospital admission. Care monitoring tools such as food and fluid monitoring charts and charts for monitoring people's sleeping patterns were in place. In addition, the service used daily evaluation records and a diary system to pass information between the staff team and respond to any issues that may have been identified. People's bedrooms were equipped with specialised personalised chairs and beds and other necessary adaptations. Each room was individually furnished and personalised.

Staff and relatives told us that people enjoyed trips out into the community regularly and that they attended events locally such as plays held at the theatre. During our visit two people enjoyed trips out into the community and staff told us people regularly enjoyed walks along the seafront and visits to cafes. One relative said, "I think that it is really thoughtful that they take X (person) out". During our visit to the home we observed people had high levels of need and there were times when they were very sleepy. Despite this, staff continually engaged with people when they were alert and people appeared stimulated by these positive engagements.

A complaints policy and procedure was in place with details about how to complain and the timescales involved. There was also information about how to complain in a written and pictorial format. The registered manager told us that there had been no complaints within the 12 months prior to our inspection and in fact there had not been a complaint since 2013. There were systems in place to gather the views of people's relatives in order to measure the standard of service delivered and to address any concerns raised. These survey results were collated

Good

Is the service responsive?

about the service overall by the organisation's head office staff. The registered manager told us she did not get feedback specific to her service, although this information would be useful.

Staff meetings took place every two to three months or on an ad hoc basis if specific messages needed to be passed on. Staff told us they had the opportunity to feedback their views either at staff meetings, in supervisions or appraisals, or by approaching the registered manager directly.

Good

Is the service well-led?

Our findings

It was clear through our discussions with the registered manager that she knew people well and sought to secure the best possible outcomes for them. Our records showed the registered manager had been formally registered with the Commission, for this service, at this location, since July 2014. She was present on each of the days that we inspected the home.

We received very positive feedback from people's relatives and healthcare professionals who worked with the service about the registered manager. One relative said, "X is great. She keeps me informed". A healthcare professional told us, "X (registered manager) is really good. She picks up on things quickly and she always gets the relevant people involved". Another healthcare professional told us, "X (registered manager) is very good at identifying issues. She is very proactive. They are very open and we have a good relationship with her".

External healthcare professionals told us the registered manager engaged with them regularly, respected their professional judgement and responded to any advice given. The registered manager told us she enjoyed good working relationships locally with other healthcare services. The atmosphere within the home was positive and the staff team told us they felt supported by the registered manager who they could approach at any time to raise concerns, issues, or to ask for assistance.

The registered manager had overall quality assurance systems in place to ensure that staff delivered care appropriately. For example, food and fluid charts, body maps, seizure monitoring charts and charts to monitor people's sleep patterns and continence were in use within the service and we saw staff using these tools effectively during our visit. In addition, the registered manager had a communication book in place for passing messages between the staff team, a diary showing actions that needed to be completed and daily handover sheets with a summary about the presentation, behaviour, needs and activities of each person. These tools enabled the registered manager to monitor care delivery and then identify any concerns, should they arise.

Records showed that a range of different audits and checks were carried out to monitor care delivery. These included medication audits, infection control audits, and health and safety audits/checks. Where issues were identified that needed to be addressed, an action plan was drafted to be used to drive through improvements in standards. This meant the registered manager had a tool in place to monitor that identified issues were suitably addressed and by which to measure progress. Monitoring was also in place to ensure that personal protective equipment supplies within the home were plentiful, bed rails were safe and the first aid kit was appropriately stocked.

Staff training was monitored at the provider's head office by a staff member allocated to this role. She liaised with the registered manager of the service to keep her abreast of individual staff members training needs and the dates by which their training needed to be refreshed.

The registered manager told us that she was supported by senior and regional managers within the service and felt she could approach her superiors at any time. She told us that where there had been internal practice or staffing issues in the past, the company sought to investigate and resolve these issues promptly. Staff meetings took place approximately every two to three months and minutes showed that key areas such as safeguarding and changes in people's needs were discussed. Minutes from these meetings were circulated to staff and they had signed to confirm they had read these. This meant staff were kept fully informed and up to date about any issues that needed to be discussed or disseminated to the team by the manager.

The provider had an innovative electronic quality monitoring system in place within the organisation that was accessed and used at this location, and also interlinked with other services and head office. The registered manager showed us that incidents such as safeguarding matters were added to the system as a report and this automatically instructed the inputting person to refer the matter to a number of other organisations, depending on the nature of the information entered. For example, when recording safeguarding matters in this system, the inputting person was prompted to raise an alert with the local authority safeguarding team (if applicable), send a notification to the Care Quality Commission and inform people's families and care managers. These actions could then be completed by the inputting person, or alternatively allocated to other staff members with a date specified by which the action had to be completed.

Good

Is the service well-led?

Senior staff produced reports from the system to be escalated to higher management and inform discussions at overarching management meetings. The reports were also used to drive improvements forward, for example by addressing gaps in staff knowledge and reflecting on actions taken. The registered manager showed us an electronic system for holding information about people and their care needs which was being embedded into the service. This maintained all information about individuals in one place and allowed for ease of updating.

Overall monthly inspections of the service had been recently introduced by the organisation based on the CQC model of inspection, including the five domains and key lines of enquiry. Records showed the registered manager had to assess and rate the service against each of the key lines of enquiry as specified in the CQC inspection model and indicate via colour coding, the compliance of the service against each of these. These monthly inspections focussed the registered manager on what to look at and where improvements were needed. An action plan was completed where any shortfalls needed to be addressed, with details of the who was responsible for addressing them, the specific actions that needed to be taken and by what date. This showed the provider sought to continually monitor and improve the service in innovative ways, by linking their quality assurance processes directly to the CQC regulatory model.

The registered manager told us the provider had a national staff accreditation scheme in place and she had nominated a member of her staff team the previous year who had won an award for 'going over and above' in respect of the way they communicated with people at the service. This showed the provider recognised and celebrated where staff excelled in their roles.