Care Worldwide (Wednesbury) Limited

Kelvedon House

Inspection report

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West Midlands
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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

Kelvedon House is registered to provide accommodation for 52 people who require nursing or personal care. People who live there may have a dementia type illness or a learning disability. At the time of our inspection 52 people were using the service. The service is delivered across three units; Park View and Jobs Way which are predominantly occupied by people who are experiencing a dementia type illness and the LD Unit which supports people who have a learning disability.

Our inspection was unannounced and took place on the 20 July 2016. At our last inspection in July 2014 the provider was meeting all the regulations but identified that some areas in the key questions of effective and well-led required improvement. We found on this our most recent inspection the provider had made the necessary improvements.

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 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 found that overall medicines were administered safely. Staff received training and had their competency assessed in relation to medicines administration. Systems were in place to protect people from abuse and harm. Staff were clear about their role in protecting people from any risks related to care delivery. Staff understood their responsibilities for reporting incidents, accidents or issues of concern. A suitable number of staff were on duty with the skills, experience and training required to meet people's needs. Recruitment processes operated by the provider were effective.

People were supported effectively by well trained staff. Staff were provided with opportunities for developing their skills and reflecting upon their practice. New staff members were provided with a comprehensive induction. People using the service who were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation were supported by staff in line with this. People's nutritional needs were well understood and catered for. People's health and wellbeing was monitored closely by staff and healthcare referrals were made as required to maintain their health and wellbeing.

People and their relatives were involved in planning care and making decisions. People were supported to make choices about all of aspects of daily living. Staff demonstrated kindness and understanding when supporting people. Staff were responsive to people when they were in discomfort or distress and provided them with reassurance and/or distraction. Information was freely available about how people could access advocacy support. People were encouraged by staff to try to do as much for themselves as possible, but staff were there to support them if they needed help. Staff were respectful towards people and provided any support they needed in a dignified manner. Staff had the confidence to challenge each other about dignity issues related to how they supported people.

People were encouraged to express their views and be involved in the planning of their care and support. People were supported to be as active as they wanted based on their personal choices and preferences. Care plans were detailed and demonstrated the level and type of support people required. The service had a dedicated activities coordinator who organised several activity sessions for people to be involved each day. People were supported to maintain and have regular contact with their family and friends. The provider used a variety of methods in order to listen to and learn from feedback from people. The provider acknowledged, investigated and responded to complaints in line with their own policy.

The registered manager had a good knowledge about the people using the service and their needs. Staff were well supported by the registered manager and they also had a number of senior staff they could access support from within service. Staff were supported through regular supervision and meetings and were clear about the values of the service and felt involved in the services development. The registered manager investigated and monitored incidents for trends to reduce any further risks to people. The registered manager was well supported by the provider. An effective system of monitoring and auditing of the quality of the service was in place.

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.

Medicines were overall well managed; they were administered, handled and stored in a safe manner.

People's care was delivered in a way that ensured they were protected from avoidable harm.

The provider operated safe recruitment practices and ensured sufficient numbers of staff were available to meet people's needs in a timely manner.

Is the service effective?

Good

The service was effective.

People were supported effectively by well trained staff.

People using the service who were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation were supported by staff in line with this.

People's nutritional needs were well understood and catered for.

Is the service caring?

Good

The service was caring.

People were supported to make choices about all of aspects of daily living.

Staff demonstrated kindness and understanding when supporting people and were responsive to people when they were in discomfort or distress.

People were encouraged by staff to try to do as much for themselves as possible, but staff were there to support them if they needed help.

Is the service responsive?

Good

The service was responsive.

People were encouraged to express their views and be involved in the planning of their care and support.

People were supported to be as active as they wanted based on their personal choices and preferences.

The provider acknowledged, investigated and responded to complaints in line with their own policy.

Is the service well-led?

Good

The service was well-led.

Staff were well supported by the registered manager and also had a number of senior staff they could access support from within service.

The registered manager investigated and monitored events within the service for patterns and trends to reduce any further risks to people.

An effective system of monitoring and auditing of the quality of the service was in place.

Kelvedon 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 20 July 2016 and was unannounced. The inspection was carried out by one inspector and an Expert by Experience. An Expert of Experience is someone who has personal experience of using or caring for a user of this type of care service.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.
Before the inspection, the provider completed 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.

We liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who used the service, five relatives, six staff members, the cook, the activities coordinator, a unit manager, the deputy manager and the registered manager. Not all the people using the service were able to communicate with us so we spent time observing them when interacting with staff to determine their experience of the service. We reviewed a range of records about people's care and how the service was managed. This included looking closely at the care provided to four people by reviewing their care records. We reviewed three staff recruitment records, five medication records and a variety of quality assurance audits.

Good

Is the service safe?

Our findings

People told us that staff supported them safely and that they felt secure. They said, "The staff are very nice and always help me" and "Yes I am safe, of course I am safe". Relatives told us, "The staff know exactly what to do to help and care for (person's name) safely".

Staff described to us how they kept people safe and how the training they received had helped them to recognise what different forms of abuse they should be mindful of, how to protect people and who any concerns should be reported to. A staff member said, "We know what to look out for and are encouraged to report anything untoward we see to (registered managers name)". The registered manager had reported any concerns about alleged abuse or harm that had occurred to people using the service to the appropriate authorities in a timely manner.

Risks to people's health and well-being were well understood by staff. Staff we spoke to were aware of the individual risks for people and told us how they supported them with these in mind. A relative described how staff managed the risk of their loved one leaving the building unaccompanied, they told us, "(Person's name) was forever trying to get out of the last home but they (staff) watch my (person's name) from a distance; (person's name) can move around here freely so I don't worry like I used to that they will get out onto the road because they are free but safe". We observed staff closely supervising people who may be at risk of falls when mobilising. For example one person was being supported by hand held support from one carer to walk from their bedroom to the lounge area; the person unexpectedly tried to sit down in the middle of this process. We saw that staff in the area were alert and responded by calmly assisting them, saying 'here you are (person's name), there's a chair behind you to sit on' and placed a chair behind the person. This meant that staff clearly knew how to support this person to remain safe but mobile whilst managing the risks effectively to allow them to maintain some independence. Records showed that risks to people's health had been assessed and were reviewed and updated regularly.

Staff were able to describe how they would deal with, report and document any incidents or accidents that occurred. We saw that incident forms were comprehensively completed and in a timely manner. Each incident outlined the immediate actions taken by staff to minimise any further risks. Each incident was analysed by the registered manager and any action plans were shared with staff in handovers and meetings, to ensure that any action taken or changes to practice were clear and understood by everyone. Staff confirmed that they were made aware of any changes to practice or learning from incidents that occurred at handover or a copy of the form was made available to them by the registered manager. A staff member said, "We get feedback about incidents, (registered managers name) tells us the outcome and it's also written down for us in the communication book".

People told us that care staff were available to them when they needed them. One person told us, "There are so many carers to help me". Relatives said, "There are always plenty of staff around and nothing is too much trouble" and "Yes there's always enough staff, even at the weekend". Staff were visible on every unit throughout the day, nearby or close to hand to support people and they were not rushed when they were attending to people's needs. The registered manager told us that they were recruiting to some vacant posts

and in the interim staff were covering any gaps in the staff rota. People's level of dependency was assessed and the registered manager used their knowledge of their needs and level of complexity to plan staffing levels. The registered manager told us that they had not needed to use agency staff for several weeks; this meant that people were cared for by staff who knew them and provided consistency in understanding and meeting their needs. Staff told us," If someone rings in sick, they (management) will get someone in to cover, the staffing is adequate here" and "No one is neglected here, people needs are all met, we work as a team to make sure; if we are left short (of staff), they (management) will try to call people in or we will swop staff around between the units to manage". One staff member said, "In the past we used a lot of agency staff who never really got to know people that well and that's really not helpful to people living with dementia, but over the last six months or so I would say, we have employed permanent staff and the training is more intense and organised. It wasn't bad before but now it's even better". The deputy manager said, "There is a set ratio of staff on each unit, cover is got in if we are short, or I will cover as I am not included in the overall staffing numbers".

Staff confirmed that the appropriate checks and references had been sought before they had commenced in their role. A staff member said, "You have to provide references and have a police check before you can actually start work". We found that processes were in place to assess the staff recruited had the right skills, experience and qualities to support the people who used the service.

People told us they were satisfied with how they were provided with their medication by staff. A person said, "They (staff) give me my tablets twice a day in a plastic pot, they tell me what they are for and encourage me to have a good drink of water, as sometimes they get stuck; they (staff) wait and make sure I have them before moving on". We reviewed five Medication Administration Records (MAR) and observed staff administering medication and supporting people to take them. We saw a senior staff member giving out the medication. They approached people, saying 'good morning (person's name), how are you?' then pausing for reply, listening and responding. They went on to say 'I have your tablets for you' and then placing them within the persons reach in a pot. They then said 'I have a drink for you as well'. One person needed a further prompt to pop the tablet into their mouth and take the offered drink. The staff member was then observed to go back to the medication trolley after each person had taken their medication and sign the MAR, before moving on to the next person. The MAR we reviewed were fully completed with no gaps or omissions evident. Body maps were in place to guide staff in relation to where and how often topical medicines such as creams should be applied. Written guidance was available for staff when supporting people with medicines prescribed to be given 'as required'.

All staff responsible for administering medicines completed the appropriate training and had their competency in administering medicines regularly checked. The appropriate risk assessments had been completed for people who had chosen to self-administer their medication. One person was prescribed a medicinal skin patch and the MAR showed that the patches were applied at the correct intervals and body maps were used to demonstrate where they had been applied. For one person a patch was alternated between only two places on the body and this was not in line with the manufacturer's guidance; however the person had not experienced any unnecessary side effects due to this oversight. This issue was raised with the registered manager and they agreed to ensure staff were made aware so that future practice was safer. Medicines were being stored securely at the correct temperatures and disposed of appropriately. Controlled drugs were kept securely and recorded correctly, and regular checks of medicines had been carried out.

Good

Is the service effective?

Our findings

People and their relatives were positive about the skills and knowledge of the staff supporting them. Relatives said, "I know the staff have had a lot of training about treating people with dignity and about dementia, that's clear anyway from the way they care for (person's name)", "Goodness me yes, the staff must have lots of training, you can tell they know their stuff" and "I am sure they (staff) are competent and well trained". Staff told us that they were well supported with training to develop their abilities and skills. They were complimentary about the training they had received and told us they felt it had equipped them to perform their role effectively. One staff member said, "I have done all my training and had updates, without a doubt it's all very useful" and "I have asked to do a first aid course and am on the list for the next one that is available". The registered manager told us that part of the conditions of staff employment was that they agreed to be enrolled on and complete accredited training, when their 12 week probationary period had finished, they told us, "It's important that staff continue to learn and develop themselves".

Staff were provided with and completed an induction before working for the service. This included training in areas appropriate to the needs of people using the service, reviewing policies and procedures and shadowing more senior staff. A staff member said, "It was very helpful shadowing other more experienced staff, it helps to get to know how to approach and support people". The provider had implemented the care certificate; this is the minimum set of standards that should be covered as part of induction training by new care workers. Several members of staff had been trained as 'care certificate assessors' to support new recruits to meet the necessary standards. Staff were closely supported within their induction period to check on their performance and progress.

Staff told us they received regular supervision. One staff member stated, "I get regular supervision and an annual appraisal, it's an opportunity to tell the manager what training you want to do" and "You get one to one supervision and you can get support anytime informally when you need it, (registered managers name) is very approachable". Records confirmed that staff were provided with protected time for supervision to discuss their development needs and any other issues they had.

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).

We checked whether the service was working within the principles of the MCA. We found that staff had received training in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff were able to demonstrate an understanding of the need to consider people's ability to give consent and what may be considered as a restriction of their liberty. We saw that people's consent was sought by staff before assisting or supporting them, for example, we observed staff knew people well and

made great effort and used any means possible to be able to communicate with them and gain their consent. A high proportion of people using the service were subject to a DoLS authorisation at the time of our inspection and staff knew how to support people with these in mind and care plans had been developed in line with these authorisations for staff to refer to.

We observed that people were enjoying late breakfasts. On the LD unit, we saw several people involved in making their own breakfast, supported and guided by a member of staff. A person said, "I like it here, I make my own breakfast you know and can get up when I want". We observed lunch on Jobs Way being served and saw that people were supported to access food and drinks in line with their needs and choices. We asked people if they had enjoyed their meal, they told us, "Yes I enjoyed it. That was lovely but the foods always lovely here" and "Yes I really like the food here, it's always very nice". One person said, "The food is very nice here. I can have what I want and when I want. I don't know what's on today but there's a menu on the wall I can look at". Relatives told us," "Its lovely here. Everyone can use the kitchenette areas to make a drink or warm things up at any time. It's like home from home" and "The food here is second to none. I eat here every day too and give my (relative) their lunch. They have some lovely food and there's always a choice of main course and pudding". The daily menu was clearly displayed in pictorial form on each unit to support people to make choices. Staff also presented people with a variety of visual prompts, for example, showing them plated up food and drink containers to support them to make their own decisions about what to eat and drink. We saw that people were given alternatives to the food on menu at their request or if staff identified that they were not eating their chosen meal.

We spoke with the chef and they told us that staff provided 'dietary notification forms' for each person, which were kept for reference and used by all the kitchen staff to ensure they were aware of people's specific dietary needs. The chef demonstrated they knew people's health and cultural needs in terms of the food that was provided, for example the daily menu included two Caribbean meal options. They told us how they fortified foods such as porridge, custard and made milk shakes to support and encourage weight gain in those people identified as nutritionally at risk. Staff we spoke to were aware of those people who needed their support to eat and drink adequately; we saw that staff were attentive and freely offered people assistance.

People had support from a range of health care professionals to maintain their health and wellbeing. Relatives said, "If (person's name) appears at all unwell, the staff will ring me and tell me and they get the doctor", "They (person's name) see the GP every few months just as routine but they always call the doctor if (person's name) seems a bit off colour; the staff are brilliant like that" and "(Person's name) wasn't very well the other week. They (staff) got the doctor straight away and then phoned me". Records showed people were well supported to access a range of health care professionals including doctors and dentists. Staff we spoke with understood peoples' individual health needs. For example we observed two staff discussing with each other their concerns that one person seemed particularly tired, which they felt may be an indication they had an infection (which they were prone to). The two staff members decided they would contact the GP to ask them to come in and see this person. This meant that the service effectively supported people to maintain good health.

Good

Is the service caring?

Our findings

People we spoke with told us they enjoyed living at the home and that staff were caring. They said, "I like it here. I am happy, yes very happy" and "The staff are very nice and always help me". Relatives said, "They (staff) are so very kind all the time; they have always been very good to (person's name)" and ""I have nothing but praise for the staff. The staff are very caring". We observed numerous kind, compassionate and spontaneous exchanges between staff and people. People were seen to be relaxed around staff with plenty of good humoured chatting taking place. We saw that staff squatted down and chatted happily with people ensuring good eye contact and clear verbal and non-verbal communication was used for effective communication. A staff member said, "Caring is about making someone feel supported, meeting their needs and promoting their independence, but most importantly making them happy and seeing them smile". Another staff member said, "Just holding someone's hand, sitting and chatting, guiding and reassuring them if they are worried or upset, it shows caring".

We saw staff regularly check on people's well-being by asking them if they were comfortable or had any requests. They spoke with people in a calm and friendly tone of voice; they demonstrated kindness and understanding when supporting them. Relatives said, "They (staff) are good at what they do. They know my (relative) very well and know their likes and dislikes" and "They (staff) know more about (person's name) than I do really". We witnessed several occasions where people who were prone to episodes of distress or agitation were diverted or reassured by staff. Staff responded quickly and quietly to these people with gentle touch and quiet words, referring to each individual respectfully, asking if they wanted to change seat, have a drink or just by holding a hand and offering comfort. For example, one person sitting in the lounge started shouting out without any identified need or trigger. We observed staff approach them, singing a song which they clearly knew and enjoyed. The person smiled and laughed then joined in and hugged the member of staff when they knelt down next to the person's chair. This totally distracted the person, eased their distress and diffused the situation.

People were supported to express their views and be involved as much as possible in making decisions about their daily care needs. We observed people being supported to make a variety of decisions about a number of aspects of daily living during our inspection, for example what activities they would like to do. Staff told us if people were unable to tell them about their personal history and preferences they would take the opportunity and speak with family members or visitors. People and relatives told us they were happy with how they were communicated with and the information they received.

We saw that information was freely available about how people could access advocacy support. Advocacy services are independent and help people to access information, be involved in decisions about their lives and explore their choices and options. The registered manager told us that people were supported to access advocacy services if they required this. Staff were aware of how to access this independent advice and support for people.

People were encouraged by staff to try to do as much for themselves as possible, but staff were there to support them if they needed help. A person told us, "I come out here for a break and a think (the garden). I

come down here and let myself out and come back in without disturbing anyone. The staff are so kind, they make me a cup of tea or I make my own. They (staff) let us do what we can for ourselves while we can". Throughout our inspection we saw people were able to freely move around and use the lift to travel up and down to other floors, unrestricted. They were welcomed, acknowledged and greeted on each floor by staff as they approached them. We saw that people's care plans were based upon their abilities and choices about how they wished to be supported. We saw that staff encouraged people to remain as independent as possible and encouraged them to involve themselves fully in completing daily living activities. For example, people who were able were supported to do things for themselves where possible, such as make or prepare their own meal or drink , pour their own juice, tidy their own rooms or collect and put their laundry away. A staff member said, "We try to keep people independent, like choosing their own clothes and supporting them to complete elements of their personal care, but with our support of course". People were dressed to their personal likes, in colours and designs of clothing which showed that their culture and individuality was respected.

People told us that staff were respectful towards them. A relative said, "The staff always listen to what (person's name) wants and respect their choices. If (person's name) doesn't want to do something or changes their mind they (staff) don't make them do it. They respect (person's name) decision" .We observed that when approaching peoples rooms staff always knocked on the door before entering and acknowledged people by name when they came into contact with them. Staff were observed communicating with people using respectful language and supporting them in a dignified manner. A staff member said, "I always make sure the person is ready to get up and help them choose what they would like to wear. I make sure I close the curtains, keep the person as covered as possible by using towels, when supporting them with their personal care".

The provider told us in the PIR they returned to us that they had nine members of staff who were 'dignity champions' and that all staff have dignity and respect training annually and as part of their mandatory training. We saw that a number of staff were 'dignity champions' as part of the Dignity in Care Initiative which enabled them to access a toolkit of resources and educational materials. The initiative encouraged people to challenge and influence others and promote the issue of dignity as a basic human right and to stand up and challenge disrespectful behaviour. The registered manager and staff told us having 'dignity champions' in the service had increased staff confidence that they could challenge each other about how they support people.

Good

Is the service responsive?

Our findings

People who were able and their relatives told us they were able to express their views and be involved in the planning of their care and support. A relative said, "I am fully involved and kept informed". The provider told us in their PIR that care plans were person centred to meet the individuals' needs and that people and their families were supported to be involved in the writing of their care plans. Whilst it was difficult for people to express how their care was personalised to their needs, we observed that care was delivered according to individual needs and wishes.

A relative said, "The staff spend time to listen, they really know (person's name) well". Care records contained personalised information detailing how people's needs should be met. Care plans we reviewed were detailed and demonstrated the level and type of support people required to reach the goals they had set for themselves. They included information about people's health needs, life history, individual interests and pastimes. We found that people were supported appropriately to address their cultural and religious needs which were considered as part of their initial assessment.

People were supported to be as active as they wanted based on their personal choices and preferences. The home was a hive of activity and held a companionable buzz about it; some people were watching TV, some reading a newspaper and listening to or chatting with visitors or staff. A person told us, "I enjoy the gardening club here. I loved gardening before I became ill. We make hanging baskets and plant small plants in pots for the garden". We observed people helping with the laundry by sorting and pairing socks. One person said, "I like washing day. It's a busy day". Others were doing some colouring and drawing. A staff member described one person who loved to knit, bake or colour but needed prompts and support with these pastimes as their dementia had affected their communication, abilities and attention span. They described how objects of reference were used such as a cup or knife and fork and pictures to help this person make simple choices. Some people were invited and encouraged to join in with some rug making whilst others were planning to go out as the weather was good.

The service had a dedicated activities coordinator who organised three or four organised activity sessions for people each day such as, cake baking, paper flower making, bingo, music to movement and gardening. We saw garden hanging baskets that people had been involved in making and keeping watered. The activities coordinator clearly knew people very well which they told us made it easier to support them with lifestyle choices and activities that were meaningful for them. They told us and we saw that each person had a personal activity plan which contained information about their likes and dislikes and life histories. This meant that the provider organised a variety of meaningful activity for people to participate in. We saw that people personalised their rooms and displayed items that were of sentimental value or of interest to them.

People were supported to maintain and have regular contact with their family and friends, either at the home or in the community where possible. Visiting was open and flexible, with relatives and visitors offered food and drinks. We saw that links with the local community had been established and people had been supported to attend several community events, for example events hosted by Age UK.

The provider told us in their PIR that quality surveys were sent out quarterly to people, their relatives and external professionals. We found the provider used a variety of methods in order to listen to and learn from feedback from people. Feedback was evaluated and outcomes
displayed on the notice board with associated actions, for example 'you said' and 'we did' action plans. A relative said, "Oh yes, they talk to us and send us questionnaires about what we like and all that, every year in fact." Meetings were regularly organised for both people using the service and their relatives. We viewed the minutes taken from these meetings and saw that it was an opportunity for a general catch up, to share developments about the service and that people were encouraged to express their views and ideas about the service.

The provider had a complaints procedure in place, which was displayed in communal areas in formats that people could understand and refer to. People and relatives we spoke with did not currently have any complaints but told us they would feel comfortable telling the staff or the registered manager if they did. A person told us, "I am happy here, I have no complaints". Relatives said, ""Everything's ok here, I've got no complaints about what they do for my (relative)" and "If I had anything to say I would always tell the manager, she would listen and do something about it". Staff we spoke with knew how to direct or support people to make a complaint. We reviewed the complaints received by the provider since our last inspection and found that overall the provider acknowledged, investigated and responded to each complaint received in a timely manner and in line with their own policy.

Good

Is the service well-led?

Our findings

People and relatives spoke positively about their experience of the home. We observed that people were happy, well cared for and appeared content. Relatives told us, "It's amazing here, they do a great job of looking after (person's name)" and "I can't thank them enough for the difference they have made to (person's name) life and mine too". A staff member said, "It's a good team here, we all work well together. I like working here".

People were able to identify who the registered manager was and told us they were visible and approachable. A relative told us, "The manager comes round most days to ask how everyone is. She's nice she is and gets things done". The registered manager demonstrated to us that they had a good knowledge about the people using the service and their needs. Comments received from professionals we contacted who had experience of the service included 'the manager has demonstrated to us that she is dedicated to maintaining a good quality of life for people and is always happy to identify potential areas for improvement' and 'it appears to us that the manager has an open door policy and that staff can approach her if they have any concerns or suggestions'.

Staff were clear about the leadership structure within the service. Staff we spoke with said they felt well supported and had a number of senior managers they could access for support from. The provider employed a unit manager on each of the three units and a deputy manager supported the registered manager. Staff were positive about the leadership of the registered manager. They said, "(Registered managers name) is very approachable" and "She is really very good and easy to talk to". The deputy manager said, "This is a new role for me and I am learning from (registered managers name). She is very supportive and always at the end of the phone if I need her". The registered manager told us that they were regularly visited by the provider and they received the support they needed from them in terms of developing and maintaining the quality of the service. Our observations on the day were that people approached the management team without hesitation.

Staff were supported through regular supervision and meetings and they were able to demonstrate to us they were clear about the values of the service said they felt involved in its development. A staff member said, "We are kept informed and asked for our views about the running of the home at meetings and we have been asked to complete staff surveys too".

The registered manager understood their responsibilities for reporting certain incidents and events to us that had occurred at the home or affected people who used the service. For example we saw that incidents were appropriately recorded and shared with external agencies. The registered manager also investigated and monitored these for trends and to reduce any further risks for people. For example, as a result of one recent incident alterations had been made to secure the fence in the garden area by extending its height. This meant that the provider used occurrences and incidents positively to reduce risks for people and enable improvements in the future.

Staff gave a good account of what they would do if they learnt of or witnessed bad practice. The provider

made the whistle blowing policy available to staff. This detailed how staff could report any concerns about the service including the external agencies they may wish to report any concerns to. A staff member said, "I would report anything I saw untoward to my manager. If my manager didn't act on the issue I would whistle blow to the local authority or you (Care Quality Commission)".

The provider told us in their PIR that internal audits were completed on a monthly basis which include infection control, health and safety, medication audits, care plan audits and financial audits. We saw that an effective system of auditing the quality of the service was completed each month; this reviewed a number of key areas of risk for the service, for example medicines management. Where omissions or areas for improvement were identified we saw that remedial action was taken. The providers Quality Team came every quarter to do a comprehensive audit of the service. Their findings and action plans based on the results were shared with the registered manager; we saw that she updated the plans when remedial action was completed and shared this with the provider accordingly. This meant that the provider monitored the service to ensure it was safe and of good quality.

The provider displayed their rating openly that was given to them by the Care Quality Commission (CQC) as is required by law. The registered manager had taken the step to clearly highlight the positive feedback received in our last report for people to see. However, they had also answered the questions relating to the negative aspects of the report for all stakeholders to view which had been outlined requiring improvement using, 'Where we fell short' and 'What did we do to improve'. This showed the provider was open and transparent about areas where they had been less effective than was desired.