Care Quality Commission

# Gary Richard Homes Limited

# Halland 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 28 April 2015 and was unannounced.

Halland House is registered to provide care for up to 30 people who have a learning disability. At the time of our inspection there were 27 people living at the service. The age range of people living at the home at the time of our visit was from 31 to 80 years. The home is run by 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.

The provider had developed a culture where people were safe. People told us they felt safe with staff and there were always sufficient staff to meet people's needs.

Staff had the required skills and abilities to meet people's needs. They received regular training, supervision and appraisals to maintain their performance and promote their development.

# Summary of findings

Staff treated people with kindness and respect. Staff spoke with people in a dignified way and knew how people liked to receive care. People told us they liked the staff and were always treated with respect and dignity. We observed good care, a gentle manner and what looked like genuine friendship between people and carers and among people themselves.

People received care that was responsive to their needs by thorough assessment and reviews of care plans, involving people or their relatives. People were involved in choosing activities, menus and the décor of their rooms. People and their relatives told us they could make a complaint and that the provider would address their concerns. People were encouraged to comment on the service through surveys and questionnaires provided to influence how the service was developed. There were audit processes in place intended to drive service improvements.

Staff we spoke with had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted.

Records showed that the Care Quality Commission (CQC) had been notified, as required by law, of all the incidents in the home that could affect the health, safety and welfare of people.

The manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. The manager had submitted a DoLS application to the local authority for all people at the home in relation to the secure main front gate. Six had been authorised and she was awaiting a response regarding the remainder.

The provider had put policies in place to support staff with medicines, safeguarding and whistleblowing. Medicines were managed safely and there were schedules and audits in place to ensure cleanliness and hygiene throughout the building was maintained.

Staffing levels were managed and planned to ensure consistency and staff who were familiar to people at the home. This was flexible with extra staffing available if required. Staff told us they worked extra shifts if needed to ensure staffing levels were maintained.

Contingency plans were in place, including arrangements for alternative accommodation and there were regular evacuation drills so that staff knew how to respond. People were risk assessed to ensure they received appropriate support to be safe in the event of an evacuation of the home.

# 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?**
The service was safe.

Staff received training in safeguarding adults. Staff understood how to identify potential abuse and understood their responsibilities to report any concerns to the registered manager.

Recruitment records demonstrated there were systems in place to ensure the staff were suitable to work with people who used the service.

Staffing levels were monitored; medicines and infection control policy and procedures were being followed.

Contingency plans were in place and staff were trained to deal with an emergency.

Good

**Is the service effective?**
The service was effective.

People received effective care from staff who had the knowledge and skills to carry out their roles and responsibilities.

Staff had training in relation to the Mental Capacity Act (MCA) and had an understanding of Deprivation of Liberty Safeguards (DoLS). Capacity assessments were completed for people, as needed, to ensure their rights were protected.

The service had close links to a number of visiting professionals and people

were able to access services.

Good

**Is the service caring?**
The service was caring.

Staff knew people well and were able to tell us how people liked to receive care.

People were actively supported to express their views and be involved in making decisions about the care.

People were treated with dignity and respect.

Good

**Is the service responsive?**
The service was responsive.

People received personalised care that was responsive to their needs.

People were supported to follow their interests and take part in social activities.

There was a complaints policy and procedure in place. People and their relatives knew how to make a complaint if needed and complaints had been responded to.

Good

**Is the service well-led?**
The service was well led.

Good

# Summary of findings

There were quality assurance systems in place to drive service improvements.

Staff meetings took place and feedback was being sought from people and their relatives to ensure they continued to meet people's needs.

The provider promoted a culture that was person-centred, open, inclusive and empowering.

# Halland 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 28 April 2015 and was unannounced.

Because of the small size of the home the inspection team was made up of one Inspector and one expert by experience. 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 looked at information provided by the local authority including the Quality Monitoring Team. We reviewed records held by the CQC which included notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the home including previous reports, safeguarding notifications, complaints and information received from members of the public.

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 home, what the home does well and improvements they plan to make.

During the inspection we spoke with the manager, four staff, and six people living at the home. We looked at records, including three support plans, daily records, activity charts, risk assessments, medicine records and observed care throughout the day. We also looked at five staff recruitment files, records of staff training, supervision and appraisal. After the inspection we spoke with six relatives and contacted a community nurse who attended the home.

Good

# Is the service safe?

## Our findings

People were safe at Halland House. One person told us, "X (keyworker) looks after me. I feel safe here." One person's relative said, "They take wonderful care of X. We're very lucky that she is there." Another told us "There is always plenty of staff."

We saw policies and procedures in place for dealing with allegations of abuse. Staff were able to tell us about different forms of abuse, how to identify abuse and how to report it. Records showed that all staff had completed training in safeguarding and received regular update training. This was confirmed in the training records. One staff member told us, "If I had any concerns I would go straight to the manager." They were able to tell us where they could find the contact number for the Local Authority safeguarding team. Staff were aware of the provider's whistle blowing policy and told us they would not hesitate to speak out if the need arose, in order to keep people at the home safe. The home had posters displayed promoting the 'Speak Out' scheme, which encouraged people to report suspected abuse.

The home was divided into three units, Ruby House on the first floor for people requiring some support, Sapphire House, on the ground floor for the people requiring most support and having the highest mobility needs and Emerald Lodge, a separate unit with its own kitchen for people who were more independent. Staffing levels were appropriate on the day of our inspection to keep people safe with three extra day care staff to make more social activities possible. We saw that people's needs were attended to promptly and people did not have to ask for support as there were always staff on hand. The manager used a tool to work out staffing levels required for each shift taking into account the number of people and the level of support they required.

The home employed sufficient staff so that they rarely had to use agency staff. When they did, they used the same staff who were familiar to the people at the home. Staff recruitment files showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were suitable. Staff were required to provide at least two relevant references from former employers and two forms of personal identification. They also had to show that they were medically fit and had all relevant inoculations. Files contained signed copies of staff employment terms and conditions and records of discipline procedures where unsafe practice had been identified. The provider followed a consistent and robust recruitment and selection process.

There was a full time housekeeper and a cleaner with responsibility for keeping communal areas clean. Care staff had responsibility for keeping peoples' bedrooms clean and hygienic, with peoples' involvement where possible. The home had a maintenance man and gardener who kept the house and gardens in good order and made sure it was a safe environment for people to live in. We saw a newly refurbished shared wet-room on the ground floor which staff told us had made personal care for a lot of the people easier and a better experience. There was a lifeline alarm sited within the wet room which meant people could summon help quickly if needed.

The home had an in-house laundry which serviced all units apart from Emerald Lodge, where people were able to do their own laundry. We saw that all people's clothing was labelled so that nobody was returned somebody else's clothes. There was a locked cupboard which stored all COSHH chemicals to keep people safe. The home used a dispersible red sack system for soiled linen to minimise infection risks for staff and people in the home.

Staff had regular fire drills and were allocated fire zones to be responsible for in the event of a fire. Staff told us fire alarms were tested weekly and we saw records of this. Emergency lighting and fire equipment was serviced and tested regularly by a contractor. Contingency plans were in place in the event of an emergency evacuation of the home. People had all been assessed and Personal Emergency Evacuation Plans (PEEPS) were on file for them which assessed the level of assistance they would require to get out of the building safely. This was based on their mobility and level of understanding. Staff were familiar with these and they had been tried and tested during fire drills. Full evacuation fire drills were carried out every six to eight weeks and all staff underwent fire training every three months. Temporary alternative accommodation had been identified and staff annual leave would be cancelled to ensure there were sufficient staff to cope in a serious emergency. The plans included contact numbers for staff, emergency services, social services, CQC and utility companies.

Good

# Is the service safe?

Any incidents involving people at the home were recorded by staff on 'Behaviour Forms' and shared during handover so all staff were aware that an incident had occurred and any action taken. These were collated and analysed so that any recurring incidents could be reviewed to find if there were any similar underlying contributory factors which could be addressed, for instance, environment, medicines, equipment or staffing. There were policies and procedures in place to ensure that other accidents and incidents in general were recorded and reviewed to see if any remedial action was required. Staff had signed these policies as read and were aware of their responsibilities in relation to them.

The provider followed relevant professional guidance about the management and review of medicines. There was a locked cupboard and a lockable medicine trolley for each unit. Medicines were stored securely and in line with guidance. The staff maintained an accurate record of the medicine that were kept in stock. This allowed them to reduce the risk of any errors occurring or running low on medicines for people. Staff only assisted people to take their medicines when they had completed medicines training and they received regular refresher training. The staff confirmed they had completed regular training in understanding how to safely store, give and record medicines.

Medicine Administration Records (MAR) were accurate and staff had recorded that people had their medicines administered in line with their prescriptions. All as required (PRN) medicines had a written authority from the person's GP. MAR sheets included a front sheet with the intended recipient's photo, a note of any allergies, and the frequency of their doses. This reduced the risk of people receiving the wrong medicine or the incorrect dose. Medicine rounds were always carried out by trained staff with a witness accompanying them who double checked the administration and recording and countersigned the MAR sheet. The Service Co-Ordinator carried out weekly checks to ensure people were provided with the correct medicines at all times.

Good

# Is the service effective?

## Our findings

Relatives we spoke with told us they had no concerns about the care of their loved ones at Halland House. One relative said, "X is absolutely safe and very well cared for. Another said, "There is always plenty of staff and you can turn up at any time." We reviewed replies to the questionnaire sent out by the registered manager to relatives and it included comments such as, "It's a lovely garden and new facilities", and "The staff are dedicated and do all they can to make X's life better." Staff told us they received a good induction which included all of the home's policies and procedures and getting to know the people there. This meant staff were trained to support people effectively and follow specific instructions in their care plans to meet their individual needs.

New staff also undertook several days shadowing an experienced member of staff and completed training in moving and handling, safeguarding, hygiene and infection control, nutrition and care planning to equip them to carry out their duties. Staff said they had meetings every two months and told us they felt their views were taken into account. They received supervision every six to eight weeks and an annual appraisal to monitor their progress, identify any training needs and review their career paths. They described the manager as 'very supportive.' This ensured that staff were supported to carry out their roles effectively because they could always seek advice whilst they provided care for people.

Staff had regular training updates and were supported to undertake further training to obtain their Health and Social Care Diploma if they wished. Staff also received training to equip them better for the support needs of the people in the home in relevant areas such as epilepsy, administering controlled drugs, continence promotion, autism and by attending learning disability and dementia workshops. This meant staff felt supported and were provided with the skills to carry out their roles and responsibilities in providing effective care.

Some people were able to communicate verbally. Other people were supported to communicate using a variety of support systems in the home. These included Makaton, communication books and picture boards. We saw activity menus in picture form within the person centred plans. One person communicated with a tablet style computer with a programme which translated their typed words into audible speech. We saw staff taking the time to chat with them and they were able to interact well and understand their support needs. Care plans included details about people's communication abilities and support methods such as objects of reference or signing. This meant people's voices were heard effectively.

Staff we spoke with had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. The safeguards apply to vulnerable people aged 18 or over who have a mental health condition, who are in hospitals, care homes and supported living, and who do not have the mental capacity (ability) to make decisions about their care or treatment. The manager had submitted a DoLS application to the local authority for all people at the home in relation to the secure main front gate. Six had been authorised and she was awaiting a response regarding the remainder.

Where necessary people's care plans contained charts containing details of their vital signs, weight, body mass index (BMI) fluid intake and urinary analysis. These were addressed under the headings; 'condition, objective, action' and included review dates and updates to the plans to achieve the objectives. For example, the care plan of one person living with dementia had the guidelines, "Condition - memory problems, Objective – help them to remain orientated, Action - single question at a time, use their name a lot, use yes/no questions." Because these details had been recorded and staff understood them and used them in practice they were able to routinely monitor people and effectively support them with their health.

Staff were familiar with people's food preferences and any special dietary requirements. Some people who were not able to take exercise were on a low fat diet to maintain a healthy weight. Care plans showed there had been assessments carried out and people or their relatives had been involved in these decisions Where appropriate, people's food and fluid intake was recorded to monitor whether they were getting sufficient food and drink. We observed people at lunchtime and saw that some people used aids to help them eat independently. One person had a plastic ring around their plate which was helping them eat without staff support.

Good

# Is the service effective?

There was a file in each of the unit's kitchens with a list of people's allergies, dietary requirements and their likes and dislikes. This included the level of support they needed to eat safely, for instance whether they had difficulty swallowing, what consistency they needed their food and whether they needed supplements. This meant that people were effectively assessed to identify the risks associated with nutrition and hydration. There was also a photo of each person with their name. This ensured that nobody was given anything to eat that might make them unwell or not be beneficial to them by new or agency staff who were not as familiar with people.

Everybody at the home underwent a full health check every year and a comprehensive review of their medicines was carried out in conjunction with their GP. This was in addition to regular routine reviews as and when people's needs changed. There was a handover at the start of every shift to ensure staff were fully aware of people's current support needs and any appointments they were due to attend. People's GP and other health appointments were held on computer and also in paper form to ensure that staff were all aware. At the time of our inspection one person was receiving regular visits because of their lack of mobility. People generally attended a nearby GP practice and the GP would sometimes attend the home. A dentist also attended the home regularly to see people who were not able or did not want to go to their own dentist. One person was receiving regular visits from a nurse to take blood samples for checking in relation to a chronic illness. In this way people were supported to maintain good health and receive ongoing healthcare support.

People were able to access nearly all areas of the home safely. Some parts of the garden were undergoing work to provide further wheelchair access. Corridors were wide and uncluttered with handrails to support people. There had been much adaptation both inside and outside the home to make life easier for people living there. The provider was in the process of extending wheelchair access in the gardens so that more people could enjoy the garden, gardening activities and the pet zoo. One of the activities arranged for people was a fitness class and the home had purchased an exercise bike for one person to help them back to fitness following a serious medical procedure. There was hoisting equipment in the rooms of people who required it. The environment in the home enabled staff to meet people's diverse care and support needs.

Good

# Is the service caring?

## Our findings

Relatives told us that there was, “Always lovely interaction between staff and residents.” We saw that people all seemed comfortable in their environment and seemed to have good relationships with staff. One staff member told us, “You form a friendship with them. I miss them when I’m on holiday.” People told us, “They’re all lovely (staff). I love it here.” We saw staff taking time to chat and interact with people when passing, not just when directly involved in personal care. They spoke to people in a kind, gentle and respectful manner and always explained what they were about to do before providing support. People were treated with kindness and compassion and their dignity was respected.

People, their relatives or representatives were involved in the planning and review of their care. One relative told us, “I am involved at every stage.” Another said, “They are always phoning to update me.” The home’s computerised care plans included records of people’s requests. Once risk assessments had been put into place, these were marked as actioned in Case Review Minutes to ensure all staff were made aware. This showed that the staff encouraged people and those that mattered to them to make their views known about their care and support and these were taken account of and respected.

Staff told us that their aim was to, “Support people to be as independent as possible.” There was a laundry which was used for most of the home, but people in Emerald Lodge were supported by staff to do their own washing. Most people were reliant on staff for food preparation. They were not allowed in the kitchen independently due to risk assessed regulations but staff told us that people could have a snack or beverage whenever they wanted. Emerald Lodge had its own kitchen and people there were involved in shopping and food preparation. Some people had their own room keys so they could have privacy whenever they wanted and come and go as they chose. This meant that people had the privacy they needed and were able to be as independent as possible subject to restrictions in place for their own safety.

Staff members’ compassion and understanding of people’s fears and needs was demonstrated throughout our visit. One person who had to go to a London hospital over several months for intensive treatment had activities timetabled into these trips to make it a less unpleasant experience for them. This included visits to an aquarium and the theatre. This showed that people

were supported by staff in a caring way when accessing other health services.

People’s dignity was respected and promoted. One staff member told us they worked to the view, “Think how you want to be treated yourself. We try to support people to be independent but safe.” Staff we spoke with told us they treated people with dignity and respect. Staff always knocked on doors before entering their room and ensured people had privacy when assisting them with personal care. Care plans we looked at reflected how people were treated with respect. People’s particular preferences and wishes were detailed and clear. Relatives told us that felt welcome at the home at any time and were able to spend time with their loved one without feeling they were in the way or a nuisance.

Staff told us that they promoted supporting people with regular toilet visits to try and limit the need for using or changing pads to maintain people’s dignity and self-respect. We observed staff gently encouraging people in this and saw it referred to in care plans. Staff looked as though they enjoyed their work and appeared very caring, gentle and respectful. One told us, “The best thing about working here is the residents, especially on holiday. You see a totally different side to them.” Another told us, “I enjoy putting a smile on their faces.” People were shown kindness and compassion in day to day care.

The home had measures in place to ensure confidentiality was observed. Care plans were on a password protected computer system kept in an office which was locked when unoccupied. People or their relatives or representatives were able to have access to these on request. Staff kept individual’s activity planners on their person so that it remained personal and private. In this way people were assured that information about them was treated in confidence.

We saw personal and sensitive end of life plans within care plans. These were written in the first person and clearly showed the person’s involvement in them. They included details of their religion, their next of kin or advocate, where

Good

# Is the service caring?

they wished to spend their final days and what sort of funeral they wanted. This went towards ensuring that people would receive end of life care in the place and way they wanted.

Good

# Is the service responsive?

## Our findings

People who were possibly coming to live at the home were assessed extensively, allowing for at least four visits, so that the person could get used to the location, people and staff gradually. This pre-assessment structure also ensured people were appropriately placed. Staff told us that care plan reviews were carried out regularly and that people at the home were involved. The home was originally a children's home and some people were placed there originally as children. People told us that as they aged the home had changed and responded to their changing support needs.

Relatives told us they were fully involved in reviews of care plans and were 'always updated' about any changes in mental or physical health. One relative told us that their loved one who had a major operation had been supported by staff with exercise and diet regimes to get back to a better level of health and fitness. This meant that had their individual needs regularly assessed and met.

The home was supported by a local learning disability community centre to facilitate Independent Mental Capacity Advocates (IMCAs) to support people at the home when necessary. Staff told us that best interest meetings were regularly held to agree important issues for people such as dental treatment or other medical procedures or around finances. These were recorded within care plans.

There was no use of any restraint within the home and staff told us that nobody there displayed behaviours that challenged. Care plans showed that best interest meetings were held when people who lacked the ability to make important decisions. This meant that people were aware of or had access to advocacy services that were able to speak for them or had their rights protected through documented meetings.

Care plans were all computerised. Staff had paper forms of a mini care plan including risk assessments so they always had access to a record of the care people needed each day. People's hospital passports with essential information about their health, medicines, diet including allergies and contact numbers to manage any transition to hospital or other services, were held on the computer and printed when they were needed. These also included details about their communication abilities, and the level of support they needed to eat and drink safely. There were guides to behaviour triggers and remedies, likes and dislikes and end of life wishes with details of their next of kin or Power of Attorney if relevant. This supported staff to provide people with care and support in accordance with their preferences, interests and diverse needs.

The provider arranged a wide range of activities both inside and outside the home to stimulate people and develop their independence. Three full time occupational activity staff were employed at the home. At the time of our visit some of the people were out on activities, walking or ten-pin bowling. People had asked at residents meetings for specific activities and these had been facilitated. These included photography, performing arts and swimming at a local pool hired privately for the home's use. Staff told us that a group of ten people had been supported by six staff recently on a holiday to Lanzarote. This holiday had been chosen and planned at residents meetings. People were also involved in planning their next holiday. People were supported to participate in activities that were important to them and protected from social isolation.

The home had responded to funding cuts around activities from the local authority by buying in a lot of their own equipment and was in the process of fitting out a new summerhouse purchased to house it all and to provide space for more activities. There was a pets' corner in the garden where people helped to look after or just pet animals, including rabbits, guinea pigs, tortoises and ducks. There were raised beds to make gardening easier for some people and a possibility for others who were not independently mobile. Residents held regular meetings to choose and plan activities within the home and holidays. They were in the process of planning a holiday to Chichester for some people. This showed that people were involved in organising activities that were important to them.

People were also involved in the menu plans for the week. They told us there was always alternatives offered if they didn't fancy the planned meal when it came to meal time. There were also regular relatives and residents meetings which showed that the provider was working in partnership with people's families to provide the best care for their loved ones. Relatives told us, "You can turn up when you want but they might not be there. They have a better social life than us!" On the day of our visit there always enough staff around to support people with mobility difficulties to engage in the activities. People told us that their friends

Good

# Is the service responsive?

and family turn up whenever they want and are made very welcome. The home had two minibuses, one of which had wheelchair access to allow people to go out on trips, shopping and holidays. Each week two people helped purchase the food from the supermarket. This showed that people were enabled and supported to maintain relationships with friends and relatives and be involved in the running of their home.

People's bedrooms were personalised and some on the ground floor had their own doors out into the garden. People's rooms were themed to reflect their interests, for example Elvis Presley, butterflies or buses. People who wanted to were able to have their own key for their rooms to give them more privacy and independence. There was a 'snooze' and sensory room, which also housed dressing up clothes which was popular with residents. During our visit one person, who did not like group activities, was sitting quietly in the room and indicated to us that they were content. People told us they were respected and accommodated in their wishes about whether they preferred a shower or bath and what time they got up and went to bed.

The provider had a complaints policy that was available to people in various formats such as easy read. The policy was contained in the service user guide given to people and their relatives. The policy stated that all complaints would be recorded, acknowledged and resolved. We spoke to one relative who had made a complaint. They told us that the provider had dealt with it in an open and honest way, quickly and to their satisfaction. The provider sent out surveys and questionnaires and had analysed the results to identify any areas of improvement which could be actioned. Comments in the surveys included, "Very friendly and person-centred staff, spotless facilities and pleasant atmosphere," and "Lots of varied activities. Homely feel." All of this showed that complaints and concerns were encouraged, investigated and responded to in a timely manner.

Good

# Is the service well-led?

## Our findings

Relatives told us that the manager had an open door policy at the home for staff and relatives. One person told us, "They're like one big happy family." They also told us there was an open and transparent culture at the home. When they had previously felt the need to complain it was acknowledged and dealt with openly and quickly. Staff told us that communication between them and the manager was good and they felt 'listened to.' This meant that the manager encouraged open communication with people, relatives and staff.

The provider c**hampioned the Speak Out scheme, whose vision is** to 'enable and empower diverse groups to come together as a strong voice for change that will create equality and promote quality particularly – but not exclusively - in health and care.' People living at the home took part in weekly meetings. The provider recorded discussion and actions points from those meetings. We checked to see whether the provider had addressed action points from previous meetings and found that they had. This included suggestions for day trips and holidays. In this way the home promoted a culture that was person-centred and empowering.

There were audits in place intended to improve service quality. The manager completed regular spot checks and supervision sessions to ensure staff were providing effective care. Staff were assessed in areas including, medicines, interactions with people and manual handling. These supervisions included opportunities for staff to identify areas of training they would like to undertake to help them provide better support for the people at the home. The home sent out regular surveys and questionnaires to relatives and health professionals and the responses were analysed to see if any action could be taken to improve the service the home provided. This showed that the home sought out the views and concerns of people, their relatives, health professionals and staff and implemented changes where necessary to accommodate them.

Regular environmental audits were carried out and recorded and any identified needs for repairs or replacements passed to the maintenance man to carry out. The cleaning schedules were subject to a weekly check by senior staff and regularly audited by the manager. This ensured standards of hygiene and cleanliness were maintained and people were protected from the risks associated with poor hygiene.

We saw a staffing evaluation tool used by the provider to gauge staffing requirements. The programme was used to plan for staffing needs in advance. This ensured that the home always had enough staff on duty to meet people's needs. Relatives told us, "Whenever you turn up there are always plenty of staff."

The provider had signed up to the Skills for Care training and support scheme which supports providers to "Make sure their people have the right skills and values to deliver high quality care," and were accredited as Investors in People. Policies and procedures were available for all staff, relatives and visitors to access if required. Staff were shown policies as part of their induction; this included the organisation's whistle blowing and safeguarding adults' policy. This showed that resources were available to staff to develop and drive improvement.

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.

CQC had been informed of reportable incidents as required under the Health and Social Care Act 2008. The registered manager demonstrated she was aware of when CQC should be made aware of events and the responsibilities of being a registered manager.

Staff demonstrated a clear understanding of what was expected of them. They were aware of their responsibilities and work they were accountable for. Senior staff were able to give a clear description of their roles and responsibilities. These included providing support to people who used the service and supporting staff either by training or supervision. Staff told us the manager was always supportive and led by example and she always made time to listen to any concerns or suggestions they had. Staff told us they were informed of any changes occurring at the service and policy changes. This meant that staff received up to date information and were kept well informed. Staff told us there was an open culture and they could talk to the

Good

# Is the service well-led?

manager about any issues. One staff member told us, “We are all one big family here.” In this way people were supported by staff who were motivated, caring, well trained, supported and open.