Leonard Cheshire Disability

The Manor - Care Home Physical Disabilities

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

The Manor - Care Home Physical Disabilities is registered to provide accommodation for up to 21 people who require nursing or personal care. This was for people with acquired brain injuries or other complex physical and learning disabilities. At the time of our inspection there were 21 people living at the service. The service is located in the village of Brampton and offers ample parking and accessible premises for people, staff and visitors.

Accommodation is provided in a combination of bungalows and a two storey building. All bedrooms are single rooms with en suite facilities. Separate facilities are provided if people preferred a bath.

This unannounced inspection took place on 9 December 2015.

Summary of findings

The service had a registered manager in post. 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.

A robust recruitment process was in place which helped ensure that the quality and suitability of staff met legal requirements. Only staff that were deemed suitable by people using the service and the registered manager were offered employment. People's needs were met by staff who had the right skills and experience to meet these in a timely manner. An effective induction process was in place to help support and develop new staff.

Staff were trained in medicines administration and had their competency regularly assessed to ensure they adhered to safe practice. Staff had been trained in protecting people from harm and were confident in their understanding of what safe care meant. Staff were knowledgeable about who they could escalate any concerns about people's safety to if they ever had a need.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager and staff were knowledgeable about the situations where an assessment of people's mental capacity could be required. All staff were working within the principles of the MCA. However, not all staff had an embedded understanding of the MCA. This meant that there was a risk of people being provided with aspects of their care that was not always in their best interests. No person using the service lacked capacity to make decisions about their care.

People's care was provided with compassion by dedicated staff who knew and understood people's preferences and how to respect these very well. People's privacy and dignity was maintained by staff using appropriate means. People were supported to make decisions about the aspects of their lives that were important to them.

People were involved in planning their care provision. This included involvement from their relatives, healthcare professionals, social workers and staff. Advocacy arrangements were in place to support those people who required someone to speak up on their behalf. Regular reviews of people's care were completed to help ensure that people were provided with care and support based upon their latest information.

People were supported to access a range of health care professionals including their physiotherapist, GP, dentist or speech and language therapist (SALT). Health care advice and guidance was adhered to. Prompt action was taken in response to the people's changing health care needs. People's health risks were regularly assessed and managed according to each person's needs.

People were supported to have sufficient quantities of the food and drinks that they preferred and staff encouraged people to eat healthily. People were supported with their nutritional and hydration needs with diets which were appropriate for their needs to help ensure they achieved or maintained a healthy weight. People had the choice to eat when and where they wanted.

People were supported to raise concerns or suggestions in a way which respected their communication skills. Staff responded quickly to any changes in a person's well-being which indicated if the person was not happy. Information and guidance about how to raise compliments or concerns was made available to people, their relative's and representatives.

Audits and quality assurance procedures in place helped identify areas for improvement and what worked well. Good practice was shared through a range of forums including visits by the operations' director, team leader and staff meetings. Staff were supported to develop their skills, increase their knowledge and obtain additional care related qualifications.

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.

People were supported with their safety. This was by staff who were knowledgeable about reporting and acting on any concerns they had.

Robust recruitment procedures were in place to ensure that only those staff deemed suitable were offered employment. A sufficient number of suitably qualified and competent staff met people's needs.

Risks to people's health were managed effectively. Risk assessments were in place for the management of risks to people's safety.

Good

Is the service effective?
The service was effective.

People were supported to make their own decisions about the aspects of their lives that were important to them. However, not all staff had an embedded understanding and knowledge of the MCA.

People's health needs were assessed and met promptly by the most appropriate health care professional.

Sufficient quantities and appropriate choices of food and drink were available to people.

Good

Is the service caring?
The service was caring.

Staff had a detailed knowledge about what was important to people and how best to meet their preferences.

People were cared for with compassion and staff respected people's privacy and dignity.

People were able to see or be visited by relatives, family members and friends at a time they wanted to.

Good

Is the service responsive?
The service was responsive.

People's preferred social activities, hobbies and interests were supported by staff who recognised how to support people to achieve their aspirations.

Information from people, their families, healthcare professionals, social workers and staff was assessed. This information was used to help ensure that any changes to people's care needs were responded to.

People's complaints, comments and suggestions were investigated and acted upon.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led.

Audits and quality assurance processes were in place and these identified what worked well and where improvement was required.

People, staff, social workers and external health care professionals had opportunities to discuss and implement best practice about their care.

An effective programme of support, training and development opportunities were in place. The registered manager kept themselves aware of the day to day culture of the service and was a positive role model.

The Manor - Care Home Physical Disabilities

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 unannounced inspection took place on 9 December 2015 and was completed by one inspector and an 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, 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 also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with eight people living at the service, two relatives, the registered manager, the operations' director, two team leaders, three care staff, the service's chef and administrator.

We observed care to help us understand the experience of people who could not talk with us. This also assisted us in understanding the quality of care people received.

We looked at three people's care plans and medicine administration records. We looked at records in relation to the management of the service such as areas covered by health and safety checks. We also looked at the minutes of management and staff meetings, staff recruitment, supervision and appraisal process records, training records, and complaint and quality assurance records.

Good

Is the service safe?

Our findings

People told us that they were safe living at the service. One person said, "If I ever ask for help the staff are always available. If they can't come straight away they always tell you [the person] why." Another person said, "They [staff] always let me know how long they will be." Another person said, "They [staff] treat me well as they know that the [registered] manager would be on their case if they didn't." Staff understood how people communicated verbally and through the use of body language and assistive technology. This is equipment that enabled people to communicate if they were not able to speak for themselves. A relative said, "I come here most days and I have no concerns about [family member's] safety. Staff are friendly."

Staff had received regular training, and updates, on how to protect people from the risk of harm. They knew how to recognise any signs of potential or actual harm, who and how to report this to, and how to escalate any unresolved concerns should they ever have a need. Information in an appropriate format such as communication cards was available to people in the service about how to report any concerns through staff, social workers and healthcare professionals. Staff had access to information on who to report any incident to and also a process whereby they could blow the whistle on any poor standards of care. One person said, "I like it here. I feel safe because there is always a [member of staff] when you need them." This meant that the provider and staff had the appropriate measures in place to help ensure people were kept as safe as possible.

Risks to people, including those for choking, being out in the community, and moving and handling were assessed and accurately recorded. Where a combination of risks were present, people's care records were cross referenced. This was to help ensure that risks were minimised or eliminated. In addition to the regular review of the risks people could be exposed to, we saw that if the need arose, prompt action was taken to manage the risks to people's health. For example, the safe use of bed rails and pressure sore prevention equipment.

We saw that people were prompted with the actions they needed to take in an emergency. This included signs telling them what to do in case of a fire, but this also reassured them that they would be kept safe. People were able to leave the service when they liked. This was supported with a register of people's whereabouts. There was a sign next to the exit reminding people to do this. People could also go out with relatives. One person told us that they had been out with their [family member] the day before. This meant that the manager and staff took appropriate steps to reduce risk.

People told us that they were able to take risks such as going out to the local village, using public transport, going flying and how they preferred their medicines to be administered. One person told us they were going to a pantomime in the service's vehicle and that staff always made sure they were secured and had their seat belt on. Another person told us about their current situation and how staff were helping them to stay safe. Staff told us, and we saw, that some people were supported by two staff or required one to one support to keep them safe from harm or the risk of harm. This was for those people whose assessed needs required this support for their safety.

Accidents and incidents, such as those for people who had behaviours which could challenge others or were at an increased risk, were investigated and action was taken to prevent recurrence. For example, there were formal and informal methods to share information about the risks each person presented with appropriate support organisations. This was to ensure that people's care was as risk free as practicable.

The number of suitably skilled staff required to support was assessed regularly. This was based on the needs of the people living in the service. We saw that there were sufficient numbers of staff to meet people's personal care needs. Staff responded to requests for assistance promptly such as acting quickly to a person's call bell. One person commented, "I feel safe living here. The staff are all so friendly and that is why I feel safe." One member of staff said, "If we need [replacement] staff due to sickness, we use the same agency staff." Staff confirmed to us that if extra shifts needed to be worked that this was always an option.

The manager had arrangements in place to ensure that there were sufficient staff when there were unplanned absences. These included staff changing shifts, working overtime and covering shifts themselves. They told us that having knowledgeable and experienced staff was the key to ensuring people's safety. One care staff said, "Most of us [staff] can and do work with everyone who lives here. It works well."

Good

Is the service safe?

Staff told us about their recruitment and induction. Checks undertaken before staff commenced their employment included their previous employment history, recent photographic identity and a check for any unacceptable criminal records. The records we looked at confirmed these had been obtained. One care staff told us about all the documents and records they had to provide as well as attending an interview before they were offered employment.

Staff were trained to safely administer medicines and had their competency regularly assessed. This was to help ensure that people were safely supported with their medicines. We found that arrangements were in place for the safe management, administration, accounting, recording, storage and disposal of people's medicines. This included up-to-date information and guidance on the level of support each person required. People were administered and supported with their medicines in a timely way. Staff told us about the requirements to support people with their medicines. For example, with people's health conditions which required medicines to be administered in a liquid format. The registered manager maintained an overview of the latest [name of organization] guidance for medicines and any changes to the dosage or format of the medicines people had been prescribed and administered. This was to ensure that people were safely supported with their medicines administration and based upon each person's needs, taking into account any health condition they had.

Good

Is the service effective?

Our findings

People told us about staff's knowledge and levels of competence in meeting their needs. One person said, "They [staff] know me so well now I rarely have to tell them what to do." The way they care for me is excellent and I love the food." We saw that staff demonstrated their detailed knowledge of each person and how best to respond to any given situation. Staff had a comprehensive understanding and knowledge of the implementation of supporting people if they required their health condition managed whilst out in the community. Where people required this support we saw that appropriate measures were in place.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We saw that processes were in place, along with risk assessments, which showed how people could take risks and make unsafe decisions [within the MCA]. No person using the service lacked the mental capacity to make informed decisions either with or without support from staff.

We found that the registered manager and some staff had an understanding of the MCA and DoLS. Although all staff had been trained in the MCA, some staff lacked knowledge about this subject. This showed us that this training had not been embedded. This put people at risk of being cared for in an unlawful way if their mental capacity changed. Staff were, however, able to tell us that if a person did not respond or consent to care in their usual way that they would escalate their concerns to the registered manager straight away. The registered manager told us that additional MCA and DoLS training would be provided and that staff's understanding would then be checked.

Staff told us that they had the training they required to meet people's needs effectively. Training deemed mandatory by the provider was planned and delivered to ensure that staff had the skills and knowledge necessary. This included subjects such as safeguarding people from harm, moving and handling, fire safety and risk assessments. This was based upon the individualised care needs of each person. Administration staff told us, "All training is planned and staff are sent a memo of when they are expected to attend." We saw that training for specialised subjects such as that for percutaneous endoscopic gastrostomy (PEG) was provided. PEG feeding is used where people cannot maintain adequate oral intake. Another member of staff said, "We get regular training which is on-line as well as face to face training for helping people with their moving and handling."

Staff gave us examples where additional training had been provided when people's needs had changed. They told us they had regular training in the administration of certain medicines for people with health conditions requiring more complex support.

We saw that processes were in place to ensure all staff received effective support. One staff member said, "I have supervisions every six to eight weeks and this is an opportunity to discuss anything affecting or influencing my work, including any of the people I care for." Another staff member said, "I have been supported from day one. It has been a gradual introduction to them [people and the service]. I have always been supported whatever the reason. If I need help I just ask." This included request for additional training if a person was planned to start living at the service with new support needs. We saw that there were processes and records for planning staff support including an annual appraisal where required.

People were provided with a weekly menu to order from with a variety of choices. One person said, "The food is fantastic. I like cauliflowers and potatoes." Another person who we saw ask for an alternative meal chose an omelette which we saw that they enjoyed. People were given the opportunity to have input into the menu and make suggestions as well as cooking their own meals. The chef showed us how people's menu choices had been developed. We saw that people were offered a choice of food and drinks to support their nutritional and hydration needs. This included those people who required a soft food or pureed diets and foods appropriate to people's allergies. This was to help keep people well hydrated and fed with a healthy balanced diet whilst respecting people's

Good

Is the service effective?

preferences. We saw that drinks were provided and were available throughout the day. People's food and fluid intake levels were recorded and monitored to ensure they received the quantities they required. One person said, "I like all drinks, tea, squash and fruit juices and the staff make them available." Other options included take-away meals where people preferred or wanted this.

During our observations of breakfast and lunch being prepared and served we saw that staff assisted some people to eat their meals. This was for people who were not able to eat as independently as others. Meals were provided at the time people wanted and were appropriately spaced. Staff also showed us how they respected people's independence to eat by themselves throughout the meals. However, assumptions were made about people's choices. For example, with the amount and placing of gravy as well as access to condiments. We saw that people were supported with their eating and drinking by staff to ensure people ate and drank sufficient quantities. People communicated their pleasure about the meal and smiled whilst other people engaged in general conversation with staff. One person told us, "That lunch was gorgeous. The food here is good. I had hot dogs and hash browns."

People, including those with complex care needs, were referred to the most appropriate health care professional when needed. This included referrals to a speech and language therapist, neurological rehabilitation and a GP. Where people's care involved complex needs a multi-disciplinary team approach was used. This included support from social services. During our inspection staff had identified a change in a person's health and responded to this straight away. Later in the day we saw that a GP had arrived and recommended the course of action for this person. People could be assured that the staff would take action to reduce and prevent any risks associated with their health.

Good

Is the service caring?

Our findings

People told us that the staff supported and cared for them in the way they wanted. One person told us, “Since the new manager arrived I can now have a bath when I want, wear the clothes I want and go out when I want. It is now my choice.” Another person said, “I get the help I need when I want it. There is no rushing. I take as long as I need.” Each person had a key worker allocated to their care. This is a staff member with specific responsibilities regarding the person they cared for. For example, keeping the relatives or family members updated about any changes in the person’s well-being. A key workers’ meeting was used to help people with their decision making in the most sensitive way. For example, where people had anxieties or complex health conditions.

We observed much laughter and expressions of pleasure and people being engaged in general conversations with each other and staff. One person said, “They [staff] are always very caring, this place is so much better [more caring] since [registered manager] arrived.” We saw that staff’s affinity with people worked for the benefit of the person. Staff were seen speaking with people in a kind and caring manner. Another person engaged in conversation with the registered manager and on leaving said, “BBFN, bye, bye, for now.” Both the person and registered manager found this amusing. If a person used a wheelchair the staff member crouched so they were on the same level. Staff were also observed asking people how they were if they hadn't yet seen each other that day. While talking to one person a member of staff came and asked if they would like a bath, the person said they were fine so the member of staff said, “Okay that's fine.” This showed that staff were caring, had built relationships and respect people’s decisions.

We listened to and observed a staff shift handover. During this it was clear that staff knew people well and the subjects that were really important to them. This included any person with anxieties, people’s life history as well as any recent changes. For example, for one person who needed an early tea as they were going out. Staff talked about each person with sensitivity and with an understanding of the person. For example, by referring to people by their name and discussing issues about their care whilst respecting people’s privacy and dignity.

People confirmed that staff were always polite and spoke to them in a respectful way. Examples included ensuring people clearly understood what they were communicating or saying to staff. One person said, “They [staff] always refer to me by my name.” We saw that the support people received was provided with compassion. One care staff said, “It is so rewarding to see the difference we can and do make.” When asked about how kind the staff were, people said, “I like them all." Another said, “I love it here, I want to stay for the rest of my life.” A relative told us, “The one thing my [family member] and I like about it here is the way staff care for people, with sincerity.”

We saw that staff regularly sought or asked about people’s general well-being and responded appropriately where this was required. For example, where people were not able to vocalise about their health condition and if it was causing them pain or discomfort. One staff member told us, “People can display facial expressions, point to objects of reference or use their assistive technology to communicate with us.” This was to indicate if they needed anything such as a drink, to go to the toilet or pain relief. We saw that regular monitoring was in place to support people who could not ask for assistance.

Staff described how they respected people’s privacy and dignity. This included closing the person’s door, talking to them in general conversation and offering reassurance throughout all personal care. A staff member said, “We [staff] give people as much autonomy as possible. Some people want us there all the time whilst others like to have a bath on their own.” Each person was seen to be wearing their emergency call device. Staff also maintained frequent contact with people and ensured people’s care needs were met respectfully.

We found that people had relatives, friends and representatives who acted as an advocate for the person if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. Other options available to people included visits by various members of the clergy and organisations such as SENSE. This is the national (UK) voluntary organization working with and supporting people of all ages who are deaf/blind or have associated disabilities.

People, and their relatives when required, were involved in the reviews of their care. There were formal reviews held twice a year and informal reviews completed by the person’s key worker through face to face meetings. This

Good

Is the service caring?

also included specific bi-monthly conversations with staff during the provision of daily care and support. We found that people's previous life history and known preferences were used to inform the person's care planning. This was to help ensure staff supported people in the most sensitive way whilst ensuring all their needs were met.

People told us and staff confirmed that visitors could call in at any time people were in the home. The registered manager told us that at weekends some people went to see relatives or spend time with their families. Staff and records we looked at confirmed this happened. One relative said that they were coming to the service for Christmas day lunch with their family member. Another person told us that their family members could visit at any time, and could take them out to the cinema, shopping or out for the day.

Good

Is the service responsive?

Our findings

People told us about and we saw recent photographs and records of the social activities, hobbies and interests they had taken part in. These included going to a local park, using electronic devices, music therapy and playing indoor board games. One person liked to knit and staff members supported them by getting them wool if they hadn't been out to the shops.

The staff organised regular trips out to various places. We saw that three people were being supported to go shopping in Milton Keynes. We also saw that a trip had been organised that evening to a pantomime. One person said, "I can't wait to go as I love pantomime." There was also an outing organised to a Cambridge University 'Varsity' rugby match at Twickenham the following day. Displays in various places at the service showed what other events and occasions such as going to the theatre had been organised and booked for 2016. A person said, "Last year they [staff] organised a visit to an airfield that has an aircraft modified so that disabled people can fly it, which I did."

Although planned hobbies and interest were in place, people could choose what they wanted to do including outings or their interests such as playing a musical instrument or going on the local guided bus way. Staff told us that people also had one to one time. This was where staff talked about people's life history and offered reassurance if people had any worries or concerns. One person told us that they had a computer and access to the internet which they enjoyed. All staff saw the potential people had and what could be used to assist people with, and not what could limit, their abilities. This was confirmed by people's care records, what staff told us and what we saw. All people's requests for assistance or support were responded to by staff with enthusiasm.

Other ways the service supported people with speaking up was through one person who represented the views of people living at the service. The person represented not just people living at The Manor – Care Home Physical Disabilities but also at the provider's other services. This was through a nationally recognised organisation that raises the profile of people with a physical disability and how various other organisations could respond to improve the quality of their lives. For example, improving technology and communication systems including accessing the internet as well as raising concerns regarding accessibility.

We saw that people who required an emergency call device were supported to access this equipment. Staff monitored people in the least intrusive manner as a result of this equipment. People were also supported with a 'hospital passport'. This was a document that detailed all the support requirements should any person be admitted to hospital. For example, what medicines the person had been administered and any measures required to ensure the person did not have cause to be anxious. This included any actions to be taken and calming measures such as how best to offer reassurance.

We saw that prior to people living at the service a comprehensive and detailed assessment of their needs was undertaken. This was to help ensure that the service and its staff were able to safely meet the person's needs. Where additional training was required to meet these needs this was provided. Examples of this were the advanced training staff had received to support people with their safe eating. This was then used as the foundation upon which each person's care needs were based. The registered manager showed us how they identified people's potential. This was by reviewing the progress each person had made and helping them to identify what their next goals or aspirations were.

People's care records were up-to-date and people were involved in developing them as much as possible. We saw that much progress had been made in developing care plans which were as individual as possible. The care plans we looked at were based on each person and the subjects that were meaningful to them. The format of the care plan was based upon what the person wanted. For example, an easy read or picture format. This helped involve people in planning their care more effectively. The registered manager said, "We are currently revising all care plans to make sure they really are 'person centred'".

We saw that suggestions from people, relatives and staff had been used to inform people's care. For example, where people started to use the service they were introduced over a period of time. This was until they and the service were sure that the person was settled and that their preferences could be met or exceeded. One person told us how they had recently had new arm rests on their wheelchair and

Good

Is the service responsive?

this had made such a difference. Other ways the service used to support people was with representatives from the Department for Work and Pensions (DWP). The registered manager told us that by these visits in person this had resulted in the review of what benefits people were entitled to. They also commented that by having DWP staff visit the service it gave DWP staff a better understanding of the positive impact they had on people's lives. We saw that where people had requested meeting minutes and other communications in a larger type format that this was provided.

People were consulted on a daily basis and given the opportunity to raise their concerns or be supported by staff and relatives who did this for them. Staff told us that people could express any dissatisfaction through their body language or facial expressions. Staff responded in a positive way to support people's requests. Information was provided on how to raise a concern or complaint and was made available to people, relatives and staff. The registered manager showed us the record of complaints and concerns that had been raised. People and their relatives or representatives knew how to make a complaint. We found of the few concerns recorded, all had been investigated satisfactorily. We saw that only the operations' manager was able to close any issues raised once they were satisfied with the outcome. This helped ensure a high standard of recognizing what areas required improvement and who had responsibility to put issues right.

Good

Is the service well-led?

Our findings

People, their relatives', and staff member's views about their satisfaction of the care provided were sought in the most appropriate way. This was predominantly by staff spending time with people and relatives, seeking their views and recognizing people's expressions and body language. One person said, "They [registered manager] have helped me a lot recently. They have been there for me especially when I needed help with my [health condition]." Another person said, "It [the service] has improved a lot. She [the registered manager] is always there. One thing that [the service] does well is the staff. I am lucky to have such good ones." Other ways that staff obtained people's views was from meetings. These were led by a volunteer. We saw that people had suggested a 'knit and natter' as well as improvements required to the dining experience.

We found that representatives of the service had been supported to attend various national meetings about people living with a disability. As part of this they had identified ways to recognize where improvements were needed. This included examples of other services that had challenged a local Mayor to travel in a wheelchair from the service into a local town. A list of action points had been made from this experience to feed back to the local authority.

One person told us, "Since [name of registered manager] arrived improvements have been made in the care we receive, the choices we have, how involved in our care [plans] as well as being there whenever we need them. I now feel happy to raise anything that bothers me. They would sort them [concerns] out for me." A relative told us, "I am really happy with the staff and management and the way they have responded to [family member's] needs." This showed us that external views were considered as part of people's care. The registered manager and staff confirmed that they were well supported. The visiting operations' manager confirmed that they visited a few times a week to provide the support the registered manager required. They said, "[Name of registered manager] has autonomy to make changes and request anything requiring approval through me."

Staff meeting minutes showed that the views of all staff groups at the service were considered. Other less formal meetings were held daily such as shift handovers. These meetings gave all staff the opportunity to be updated about any changes or developments planned at the service. For example, improvements to the building structure and layout. This was to provide a better environment and have a sensory room, separate dining room and a better lift with wider access. The registered manager told us that people had been fully involved and informed about the planned changes. One person said, "I am looking forward to the new building with more space." Other subjects discussed included medicines administration guidance, allergens policies and health and safety. This information was used to drive improvement in the standard of service provided. We also found that the registered manager held a 'gossip' session. This was an opportunity for staff to be as open as possible about any issues affecting their work. Staff told us this was a positive option which they used to the service's benefit.

Strong links were maintained with the local community and included various trips out to shops and swimming pools as well as the use of public transport to access local towns and cities. One person said, "One of the major improvements has been the new [registered] manager." They told us that people were much better supported to do the things that were important to them. Relatives and volunteer groups supported people living at the service with trips to a local park as well putting up decorations and ornaments that people liked. This included a well-known banking provider as well as representatives from the DWP. We saw that there were Christmas decorations in the entrance area, lounge/dining room as well the conservatory. One person confirmed that they had been supported by local volunteers who had taken leave to help put up the decorations. This had a positive impact on the person's life as well as engaging with the local community.

We found that the staff structure supported the registered manager in their role. The registered manager had created four team leader positions as well as a career path for all staff. Additional leadership training was being provided on subjects including medicines ordering and shadowing staff. Staff spoke confidently about the provider's values of putting people at the forefront of everything. They were also regularly reminded of their roles and responsibilities and how to escalate any issues or concerns they became aware of, to management. The registered manager also completed spot checks and worked with staff at nights/ weekends. This was to mentor staff with key skills whilst

Good

Is the service well-led?

also identifying the staff culture. A relative said, "[Name of registered manager] is always out and about the home. They always listen to what I have to say even if they are busy."

Staff all told us that they would have no hesitation, if ever they identified or suspected poor care standards in whistle blowing. This was by reporting their concerns to the provider using an anonymous reporting system. Staff also told us that they could do this without any fear of recriminations.

The registered manager had provided consistency and continuity of care provision. We found that people who used the service had been involved in their recruitment. One person said, "This was to make sure they [potential staff members] would fit in with us all." The registered manager confirmed that this was the case. They said that having a person who used the service interviewing was an important part of the staff recruitment and selection process.

Quality assurance procedures, spot checks and audits completed by the provider, registered manager and team leaders had ensured that deficiencies had been identified in the standard of care provided and any necessary action had been taken. This included out of normal hours checks. This was to help ensure that the right standards of care were being provided as well as reminding staff, and ensuring, that all medicines were safely recorded and accounted for. Any areas requiring improvement were raised with individual staff members, or for more general themes, at a staff meeting.

People, staff and visitors we spoke with were complimentary about the fact that the registered manager was a very approachable person. We saw that they and all staff worked as a team. We saw that all staff were supportive of each other. All staff commented on how supportive the registered manager was and the positive difference they made to the quality of people's lives and the running of the service.

The registered manager attended the provider's and managers' meetings where information was shared on good and best practice. For example, improving the communications with family members and general challenges faced by care providers. Staff champions were in place for subjects including nutrition and diabetes care. This was to develop staff skills throughout the service and improve the quality of service provided. From our observations throughout the day we saw that despite some people's complex care needs, staff had made significant progress with developing people's communication skills. This showed us the provider strived for improvements in the quality of care its staff provided.

Staff members training completion and achievements were frequently monitored to help ensure the right standards of care were maintained. Staff needing any updates, new training or refresher training were sent a memo to remind them when and where to attend. The registered manager was keen to develop staff's knowledge. For example, by encouraging new staff to complete the Care Certificate [a nationally recognised training standard]. This included mandatory training in basic life support. One care staff said, "When I first started I had a lot to learn but I have been supported all the way. If I needed, or asked for, any additional support it was provided. Staff confirmed that any training to meet people's care needs was always provided. For example, updates to those people supported with PEG feeding. We saw that this training was planned.