Alexander's Mental Health LTD

Park Avenue Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 25 April 2017 and was unannounced. Park Avenue Residential Home provides residential care without nursing for up to 25 younger people with a primary mental health diagnosis. The service is comprised of two Victorian houses number 74 and number 76; one accommodates women and the other men. The two houses are not joined but have communal access to gardens and a shared parking area at the rear of the properties. At the time of the inspection there were 19 people living there.

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.

Staff had undergone safeguarding training and had access to policies and guidance to enable them to safeguard people from abuse.

People had detailed and comprehensive risk assessments in place which were actively reviewed with them to ensure they remained up to date and relevant. Staff understood how to respond to emergencies when they arose. The provider had ensured that the premises and service were secure and safe for people.

A higher level of staffing had been maintained for the number of people accommodated to allow for the induction of new staff. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

People received their medicines safely from trained staff, who were provided with relevant guidance about the administration of people's medicines. There were processes in place to ensure the safe ordering, storage and disposal of medicines.

Staff received a comprehensive induction to their role. People were supported by staff who were offered a broad range of training opportunities relevant to their role to ensure they could support people effectively. Staff were well supported within their role through the supervision process.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were involved in the meal planning within the service and had a choice of hot meal. People were encouraged to eat a balanced diet and healthy eating was promoted. People were encouraged where possible to be independent in the kitchen.

Staff spoken with were knowledgeable about people's health care needs and people's care records contained any relevant guidance required by staff to ensure their health care needs could be met effectively.

People experienced positive relationships with the staff who provided their care. People seemed very relaxed with the staff and clearly enjoyed their company. Staff demonstrated concern for people's welfare. Staff supported people appropriately to make their own decisions.

Staff were observed to be respectful of people's wishes. Staff were careful not to speak with other staff about issues in front of people. People were provided with information about their rights within the service. People's needs in relation to their privacy and dignity had been met.

People were provided with a comprehensive pre-assessment prior to their admission to the service. People had support plans in place that had been discussed and agreed with them in order to identify what their care needs were and how they wanted them to be met; these were reviewed with them at least monthly. Staff had access to clear and individualised guidance in relation to meeting each person's mental health needs.

People's needs for stimulation were met in varied ways that responded to their individual interests and preferences. People were able to access a range of activities both on-site and in the community. People were encouraged to retain or develop their levels of independence.

The provider's aims for the service were clearly stated in their statement of purpose. Staff were observed to uphold the provider's values in the way in which they supported people with their care. There was an open and transparent culture within the service.

There was a clearly defined management structure and staff understood their roles and responsibilities. Staff told us the service was well-led and that the registered manager was available and approachable. The registered manager demonstrated a sound knowledge of the challenges facing the service, for example, in relation to staffing.

People had been involved in quality assurance processes and their feedback had been used to make improvements to the service. People's complaints were investigated, responded to and any required actions taken.

Various aspects of the service were audited on a daily, weekly and monthly basis. The results of audits had been used to improve the quality of the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had been safeguarded from the risk of abuse.

Risks to people had been assessed and managed for their safety.

There were sufficient staff to meet people's' needs. Staff's suitability for their role had been assessed to ensure people's safety.

People's medicines were managed safely by trained and competent staff.

Is the service effective?

Good

The service was effective.

Staff had the necessary skills and knowledge to carry out their roles effectively for people.

People's treatment was provided in accordance with legislation and guidance, where they lacked the capacity to consent to specific decisions about their care.

People were supported to eat and drink sufficient for their needs and to maintain a balanced diet.

Staff supported people to ensure their mental and physical health care needs were met.

Is the service caring?

Good

The service was caring.

People experienced positive relationships with the staff who provided their care.

Staff supported people appropriately to make their own decisions.

People's rights to privacy and dignity within the service were

respected and upheld.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. People were fully involved in drawing up their support plans which reflected their needs, preferences and interests.

People's needs for stimulation were met in varied ways that were responsive to their individual interests and preferences.

Processes were in place to enable people to express their concerns, and complaints and these had were investigated and responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The provision of people's care was underpinned by a clear set of values which staff applied in their work with people. There was an open and transparent culture within the service.

There was a clearly defined management structure for the service which was well-led by the registered manager.

Processes were in place to audit and monitor the quality of the service provided and to drive service improvement for people.

Park Avenue Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 25 April 2017 and was unannounced. The inspection team included an 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. The expert by experience had experience of using mental health services.

We did not ask the provider to complete 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, instead we requested this information at the inspection. Prior to the inspection we reviewed information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we spoke with a nurse and a social worker about the service and received written feedback on the service from a pharmacist. During the inspection we spoke with nine people. We spoke with four care staff, the registered manager and the provider.

We reviewed records which included three people's care plans, four staff recruitment and supervision records and records relating to the management of the service.

Since the last inspection of this service the provider has changed their legal entity. This is the first inspection of this service under the new legal entity.

Good

Is the service safe?

Our findings

People told us that the service was safe. One person told us "It's a lot safer here than other places. It's a safe atmosphere. When I get back here I feel safe again." Other comments included "Oh yes, I feel safe." One person did not feel as safe due to the number of recent staff changes in the service. People told us they received their medicines on time and that there were sufficient staff to meet their needs.

The social worker and the community psychiatric nurse we spoke with told us people were safe within the service. A member of staff told us "The building feels safe."

The registered manager told us the provider required staff to undertake face to face safeguarding training upon commencing their role, which they then updated annually, this was confirmed by records. Staff spoken with were able to demonstrate their understanding of the safeguarding process and their role and responsibility to protect people from the risk of abuse. Staff had access to both the provider's safeguarding policies and the multi-agency safeguarding procedures.

The registered manager understood their role in safeguarding people from the risk of abuse; since the provider had changed legal entity they had needed to make one safeguarding referral to the local authority to safeguard a person and appropriate measures had been taken to ensure the person's safety. People were safeguarded from the risk of abuse.

The provider had a clear and comprehensive referral form professionals were required to complete for people when referring them to the service. Professionals were also required to submit copies of people's risk assessments with their referral. This ensured the provider had sought information regarding people's vulnerabilities and potential risk factors, to support robust decision making in relation to people's potential risks if they were accommodated.

Staff completed a risk assessment checklist with people when they were accommodated. This covered risks to the person in relation to: their physical health, mental health, mobility, medicines, personal care, continence, communications, diet, religion, relationships, household, social, community, transport, work and finances. If any risks were identified from the checklist these were then cross-referenced to in-depth individual risk assessments for the person. These identified the risk, the risk rating to determine the level of risk, who might be affected, the control measures and any further action required. The risk assessments were signed by people which demonstrated their involvement in the process and their agreement with their content. Staff then reviewed the risk assessments with people either on a monthly basis or sooner if an incident occurred. All staff were then required to read and sign people's risk assessments to demonstrate they were aware of the associated risks for the person. People had detailed and comprehensive risk assessments in place which were actively reviewed with them to ensure they remained up to date and relevant.

People had in place a personal emergency evacuation plan (PEEP), to ensure staff had guidance regards people's support needs in the event of a fire. Processes were in place to ensure staff were aware of when

people were leaving the service, where they were going and their expected time of return. People also had a missing person's profile providing essential information about the person and an up to date photograph in the event they went missing. Where staff had identified risks to people that required them to be monitored for their own safety, records showed that regular observations in relation to the person's location and welfare were completed and documented as required. Records showed that staff had responded promptly and appropriately to a recent incident to ensure the person's safety. Staff understood how to respond to emergencies when they arose.

The service had a business continuity plan which outlined how incidents would be managed for people's safety. Staff completed daily health and safety checks and records showed that relevant safety checks had been completed in relation to gas, electrics, water and asbestos. The provider had ensured that the premises and service were secure and safe for people.

The provider had assessed the staffing requirements for the service. The registered manager told us the service was staffed with three care staff on the early and late day shifts and two waking night staff, which records confirmed. An additional member of staff was rostered to provide activities on four of the week days. There was a chef employed on week days in addition there was a housekeeper. The registered manager told us the current level of staffing was based on the service being full. However, they had been recruiting a number of new staff recently and therefore had retained the higher level of staffing to ensure there were sufficient numbers of experienced staff to support the new staff through their induction period. Staff confirmed that there were sufficient staff to meet people's' needs.

Staff told us and records confirmed they had undergone robust recruitment checks as part of their application for their post and these were documented in their records. These included a full employment history, the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment, a health declaration, interview record and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One staff record reviewed did not contain the staff member's date of completing full-time education and their employment history. We spoke with the staff member about this and arrangements were made for this information to be documented on their file. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

The registered manager told us staff underwent medicines training when they commenced their role and their competency to administer people's medicines safely was assessed, which records confirmed. Staff were then required to update their medicines training and competency assessments annually to ensure they remained competent to administer people's medicines.

There were processes for the safe ordering and disposal of medicines. Medicines were stored safely. Most people had their medicines stored in their bedrooms in a secure cabinet; there were daily checks on the cabinet temperatures and the fridge where medicines were stored to ensure they were within a normal, safe range. Staff checked the amount of people's boxed medicines each time they administered them. If people required topical creams or inhalers these were labelled with the date of opening to ensure they were only used within the recommended timescale. Some prescription medicines are controlled under the Misuse of Drugs Act 1971; these medicines are called controlled drugs or medicines. Appropriate storage was in place for controlled medicines.

Staff administered people's medicines in pairs, to ensure two staff were responsible. They checked that the person was ready to take their medicines and that they knew what they were taking. Staff and the person

then jointly signed the medicine administration records (MAR) once staff had administered the medicine. People were encouraged to be as independent as they were able to be with their medicines administration and some people self-medicated, following assessment of any associated risks. Staff were observed to administer people's medicines safely.

PRN protocols were in place for people. These are used for the administration of medicines that are to be given 'as required'. These include information such as the medicine and dosage, conditions under which it should be given, minimum time between doses, the maximum dose in a twenty-four hour period and when medical advice should be sought. Staff had access to relevant information about people's medicines.

Good

Is the service effective?

Our findings

People felt that staff had the correct skills to assist them effectively. They told us their consent was sought for their care. People were satisfied with the quality of the food provided. Their comments included "The food the chef cooks is still better than food that used to be delivered" and "Quite good." People felt well supported with their health care needs.

Staff told us and records confirmed they had received an in-house induction upon commencing their role with the provider, this included a period of time spent shadowing more experienced members of staff in order to familiarise them with their role and responsibilities. New staff undertook the Care Certificate which is the industry standard induction for staff new to care. Staff received a comprehensive induction to their role.

Staff all undertook the provider's mandatory training which included areas such as: moving and handling, infection control, challenging behaviour awareness, equality and diversity, food hygiene, record keeping, mental health awareness, emergency first aid and health and safety. Records demonstrated staff were either up to date with their required training or were booked to attend courses. The provider had an annual face to face training schedule to ensure staff could access training opportunities or refresher training as required.

In addition to the provider's mandatory training, staff were encouraged to undertake additional training to further develop their knowledge of working with people living with mental illness. Subjects covered included: impact of mental illness, treatment, legislation, care planning, relationships, independence, managing change and working with others. Training sessions had been booked for those staff who had not yet had the opportunity to complete all of these modules. In addition some staff had undertaken training in relation to how to empower women and three staff had completed drug and alcohol training. People were supported by staff who were offered a broad range of training opportunities, relevant to their role to ensure they could support people effectively.

Staff told us felt supported with their work; records confirmed they received regular supervision. This enabled staff to reflect upon their practice in relation to the provision of people's care and to discuss any issues for people. In addition staff received an annual appraisal of their work, which provided them with the opportunity to reflect upon their performance over the previous year and to identify developmental opportunities for the coming year. Staff were well supported within their role through the supervision process.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they had undertaken training in relation to the MCA and DoLS which records confirmed and they were able to demonstrate how the MCA applied to their day to day work with people. No-one within the service was subject to DoLS. Records demonstrated that where staff had identified that people might lack the capacity to make a specific decision they had contacted professionals and completed a mental capacity assessment and best interest decision on the person's behalf. This had ensured that people's treatment was provided in accordance with legislation and guidance.

The provider now employed a chef weekdays rather than staff on shift preparing people's meals to ensure people's nutritional needs were met. At the weekends the care staff prepared the main meal. People were provided with a hot main meal each day which they chose when to eat. There was a choice of two main meals which had been selected by people. On the day of the inspection the chef was not working, staff prepared the main meal and were heard to seek people's feedback on the meal. People were involved in the meal planning and had a choice of hot meal.

People were weighed regularly with their agreement to enable staff to monitor if they remained at a healthy weight and to identify if any action was required. Staff appreciated that a number of people were aiming to reduce their weight. They encouraged and supported people to make healthy choices about the foods they ate. For example, baked sweet potatoes were served with lunch instead of chips. The lunches were served with either vegetables or a salad. People were encouraged to eat a balanced diet and healthy eating was promoted.

People's level of independence in the kitchen was assessed and people were encouraged to be independent where possible. Some people prepared some of their own meals during the week with staff support instead of having the hot meal provided. People had access to foods to prepare themselves breakfast and an evening snack. People had access to facilities to make themselves hot and cold drinks. People were encouraged where possible to be independent in the kitchen.

People had health care files in place which contained a health action plan, detailing what the person's health care needs were and how these were to be met. Records showed people had seen health professionals which included: psychiatrists, GP's, social workers, community psychiatric nurses, dentists and opticians. People's health care visits were documented on a medical consultation form which people sometimes completed themselves in order to demonstrate how their health care needs were being met. Staff spoken with were knowledgeable about people's health care needs and people's care records contained any relevant guidance required by staff to ensure their health care needs could be met effectively. Staff were observant of people's mental state and understood people's physical health care needs. At the staff shift handover staff discussed a person's health care needs and made arrangements to contact relevant professionals to ensure the person's needs were met. Staff supported people to ensure their mental and physical health care needs were met.

Good

Is the service caring?

Our findings

People told us the staff were caring and respected their privacy. A person told us "Staff are spending time with people." All but one person spoken with enjoyed living in the service. People told us they were involved in decisions about their care.

Staff told us that when they commenced work they had spent time reading each person's care records in order to familiarise themselves with the person's history. They told us they then spent time chatting with people and getting to know them. Staff said "We build relationships with people steadily" and "I sit down and have a chat with people." They also told us they spent time with people doing the things they enjoyed to get to know the person. Although staff keyworked specific people and therefore had responsibility for that person's support plans and reviews, they all worked across the two houses and spent time with everyone. This enabled staff to develop a relationship with each person.

Staff were observed to interact with people politely and appropriately to the situation. For example, when administering peoples' medicines staff ensured they remained focused on the task for the person's safety. At other times staff were observed to interact with people in a jovial manner. People seemed relaxed with the staff and clearly enjoyed their company.

At the shift handover staff reported that a person had gone out from the service as planned the evening before. However, as they were late returning, staff had contacted the person to check upon their welfare and to ensure that they were alright. We observed a person showed signs of becoming anxious. Staff were quick to respond, checking to ascertain what the cause of their anxiety was and offering them guidance and reassurance. Staff demonstrated concern for people's welfare.

The registered manager told us some staff needed guidance on how to interact with people when they first commenced their role, in terms of tone and manner. They provided an example of how a person had expressed a concern about the quality of a staff member's interactions with them; this was then addressed with the staff member to ensure they understood how the person wanted them to interact with them. People were able to provide staff with feedback on their relationships with them and this information was used as an opportunity to support staff with their development within their role.

A person's support plans stated that one of their objectives was for staff to assist them 'to make informed choices.' Staff told us they spoke with people about decisions so that they gained the person's views and involved them in the decision making process. Staff said "We ask people what they want, listen to them and come up with solutions." We heard staff providing people with relevant information which they then used to make to make their decision about their care. People were observed to follow their own personal routine and to get up when they were ready. Staff supported people appropriately to make their own decisions.

A person had expressed a wish about where they wished an aspect of their care to be provided; staff were aware of this and were seen to respect the person's wishes. Other people preferred to receive their support from staff of a specific gender, this was noted in their support plans and routines had been adapted to

ensure their wishes were respected. We heard staff ask a person if they would like to participate in a planned activity and they were respectful of the person's wish not to. Staff were observed to be respectful of people's wishes.

Staff told us they were always mindful of the need to uphold people's privacy and dignity. People had a key to their bedroom. Staff were observed to knock and only enter a person's bedroom with their permission. We observed that staff spoke in private with people about any issues they wished to discuss. Staff were careful not to speak with other staff about issues in front of people.

A copy of the service user's charter was displayed, stating that people had the right to be consulted and to have their views listened do about any provision that directly affected them as an individual. Advocacy information was displayed for people which they were supported to access where required. People were informed of their rights to read their records and some people chose to write in their own care records. People were provided with information about their rights within the service.

The division of the service into male and female houses ensured that whilst people of both genders socialised together where they wished to; women had access to their own bathroom facilities. It also ensured that women had their own living space within the service. This was particularly important for some women as their personal histories had made them potentially more vulnerable when living in a mixed gender service. People's needs in relation to their privacy, and dignity had been met.

Good

Is the service responsive?

Our findings

People told us they had been involved in planning their care within the service. People said they knew how to make a compliant if they needed to. People told us their views of the service had been sought and most of those spoken with felt listened to.

People were provided with a comprehensive pre-assessment prior to their admission. The registered manager assessed the person's needs and spoke with them, their relatives and professionals involved in their care. In order to gain an understanding of what support the person required, in relation to: their mental health, physical health, risks, vulnerability, support needs and activities. The assessment also involved assessing the person's compatibility to live with the people already accommodated. People living in the service were consulted about potential new people moving in. If the assessment process identified that the service was not suitable for that person's needs, then they were not admitted. If people were offered a placement, then they were provided with a transition plan to support them with their move into the service.

Each person had a pen picture, which provided key information about the person. Although the service did not use agency staff, this provided staff with a brief overview of the person, which was useful, for example, when new staff were familiarising themselves with peoples' care needs.

People had support plans that had been discussed and agreed with them. Within each support plan it was identified what the person's identified support need was, their aims and objectives and an action plan detailing how they would be met. Each person had a staff member allocated as their keyworker who reviewed their support plans with them at least monthly and more often if changes occurred to ensure they remained relevant and up to date. The monthly review demonstrated how people were being supported to achieve their personal aims and objectives. For example, one aim for a person was to increase their exercise, records showed staff had supported them to attend a sport which they had expressed an interest in. People were fully involved in writing and reviewing their support plans.

People's support plans detailed their mental health diagnosis, symptoms and treatment. There was guidance for staff about what signs would indicate the person was coping, proactive strategies to maintain the person's well-being, signs that would indicate the person was becoming unwell and early intervention strategies. Signs that would indicate the person was in crisis and the actions for staff to take. People also had behaviour support plans which identified which triggers were more likely to cause a person's behaviours. Staff had access to clear and individualised guidance in relation to meeting each person's mental health needs.

Staff spoken with demonstrated a good understanding of people's individual needs and how these were to be met. Staff were able to tell us about people: what interested them, how they liked to spend their time, what distressed them and how they supported people at these times. People were supported by staff who had a good understanding of them.

Staff received a full and comprehensive handover when they commenced their staff shift. This ensured they

were kept informed of people's: welfare, mental state, any specific risks to people, anyone on regular observations for their safety and any appointments that people required support to attend. Staff used the shift handover and team meetings as opportunities to highlight any issues or behaviours they had observed and to discuss any actions that were required to be taken or strategies to manage the situation for people. For example, night staff had made an observation about a person's behaviours and discussed at the shift handover how they had tried to talk to the person and then used distraction techniques to assist them. Staff shift handovers and staff meetings were an effective method of updating staff about people and sharing information.

People were offered a range of activities both within the service and in the local community. In addition to a weekly service activity schedule, people had their own personal activity schedule. People were consulted about their hobbies and interests and activities were planned in response to their feedback and that of professionals involved in their care. Staff told us "People lead what they want to do" and "I ask people what is it you want." Activities people were currently involved in included: for example, coffee mornings, pampering sessions, dancing, board games, BBQ's, well-being groups, singing and various sports. Activities people had previously been involved in included: college courses, Prince's Trust and voluntary work. During the day of the inspection people participated in a coffee morning, a trip out and a gardening activity. A day trip was being arranged to a tourist attraction for people. The provider had created a small gym on-site for people to use. This was of particular benefit to those people who enjoyed this activity but who did not wish to use a community gym. If people wanted to attend a particular group for example, a women's only group, then this had been arranged by staff for them.

Staff documented in people's records the activities they participated in, so there was clear evidence of each person's activities and a record of why they had not attended any planned activities. People's needs for stimulation were met in varied ways that responded to their individual interests and preferences.

A person had recently moved to more independent living. Records showed people were encouraged to visit the shops themselves, assist with cooking if they wished to, do their laundry, clean their bedrooms and to use public transport. People were encouraged to retain or develop their levels of independence.

People were also supported to maintain relationships with their families or people who were important to them where they wish to do so. People's wishes regarding whom they wished to maintain contact with were respected.

People understood how to make a complaint if they wished. Information telling people how to make a complaint was prominently displayed within the service. Records showed that where complaints had been received they had been investigated, responded to and any relevant actions taken on behalf of people. People's complaints were investigated, responded to and any required actions taken.

People's views of the service were sought through residents meetings, the last of which was held on 28 February 2017. Records showed people had been asked for their feedback on both the food and the activities they wished to participate in. People also had the opportunity to raise any complaints at these meetings. Processes were in place to enable people to raise concerns.

Good

Is the service well-led?

Our findings

People told us there was open communication within the service from staff. Most people spoke with felt the service was well managed. Their comments included "The management team are good," "Very well" and "Generally okay."

The provider's statement of purpose outlined the aims of the service as being to provide 'recovery focused support, based on a culture of valuing and enabling the individual to achieve their outcomes in a safe and open environment.' Staff told us they learnt about the provider's values during their induction. Staff were observed to uphold these values in the way in which they supported people with their care.

There was an open and transparent culture within the service. Providers are required by law to notify the Care Quality Commission CQC of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found that the service had met the requirements of this regulation.

Staff told us they were encouraged to speak out about any issues and had access to a whistleblowing policy in the event they needed to raise any concerns. There were regular staff and senior care staff meetings to provide staff with the opportunity to express their views. Staff told us they had provided feedback on the existing staff shift handover records, which records confirmed. As a result of their feedback the records had been reviewed and amended. Staff had been asked for their views and these had been acted upon.

Staff were required to read the provider's policies and to sign to say they had done so; revised policies were also circulated for staff to review. The provider ensured that staff were kept updated and informed regards the policies and procedures that governed the provision of people's care.

It is a condition of registration with CQC that the service has a registered manager in place. There was a registered manager registered with CQC to manage the service.

The management team comprised of the registered manager, a deputy manager and three senior care staff. The deputy role was currently vacant and had been recently advertised. Each staff shift was led either by one of the senior care staff or by an experienced member of staff who was allocated as the shift lead. Their duty was to allocate responsibilities for staff during the shift and to lead the staff team. This ensured staff had clear guidance about where to seek support and leadership during the shift for people. Staff told us "Shift planning is working well" and "They instruct us." There was a clearly defined management structure and staff understood their roles and responsibilities.

Staff told us the service was well-led. Their comments included "You can go and ask questions" and "The providers come by, they are supportive with issues." They also commented "X (registered manager) is a good manager. He motivates me to do my best" and "I feel valued." Staff told us the registered manager was available and approachable.

The provider told us they supported the registered manager in their role through regular visits and support telephone calls, in addition they provided the registered manager with supervision on a two monthly basis. The registered manager was well supported by the provider within their role.

There had been recent changes within the staff team, with staff leaving and new staff joining. The registered manager appreciated the need to both ensure they had the right staff in post and to create stability within the staff team for people. They had also taken action to ensure that the processes within the service were robust to ensure people's safe and effective care. Staff told us there had been a lot of improvements within the service and commented that the paperwork was "A lot clearer now." The registered manager demonstrated a sound knowledge of the challenges facing the service.

People, their relatives, professionals and staff were asked to complete an annual quality control questionnaire to seek their feedback on the service provided. The last survey was published in January 2016 and demonstrated what actions had been taken in response to peoples' feedback. This year's survey had been circulated and the registered manager told us that due to the recent changes in staffing the completion of the survey and the collation of the results had been delayed. However, this work had been assigned to another member of staff and was in the process of being completed for people.

People had been involved in drawing up their own improvement plan for the service in November 2016 when they had been consulted about what areas of the service they would like to see improved. People had identified that they wanted a chef employed and this had been arranged, they also wanted more pictures for the service and these had been purchased. Although the provider had not been able to meet all requests those which were practicable and improved the quality of the service people received had been met. People had been involved in quality assurance processes and their feedback had been used to make improvements to the service.

The registered manager and the provider both completed alternative bi-monthly audits of the service so that the service was audited on a monthly basis. This also ensured that the provider had oversight of the quality of the service in addition to the registered manager. The registered manager's audit reviewed areas such as: new people, incidents, complaints, safeguarding's, staffing, and training. Records demonstrated actions required as a result of these audits had been completed for example; the service user welcome pack had been recently updated and staff had updated their safeguarding training to ensure their knowledge remained up to date for people.

Other areas of the service audited included: medicines, finances and health and safety. Staff told us if any issues were identified within their daily health and safety checks then these were passed to the maintenance team to be addressed for people. The provider's medicines were audited both internally and then externally by their pharmacist who was completing their annual audit on the day of the inspection. The pharmacist had informed us prior to the inspection that they had no concerns about the management of medicines at the service. Staff documented and reported any accidents or incidents which the registered manager then reviewed and monitored to reduce the risk of future repetition for people. These were then also discussed within the staff shift handover to ensure all staff were aware of any changes to people's care following incidents.