Care Quality Commission

Rosecroft Care Limited

Littlecroft

Inspection report

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New Romney
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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 was carried out on 14 February 2018, and was an unannounced inspection.

The service Littlecroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service was not registered to provide nursing care. The service provides accommodation for up to nine people who have learning disabilities. There were five people living at the service at the time of the inspection. The service Littlecroft is a residential care home located in New Romney and consists of two neighbouring chalet bungalows in a residential area.

At the last Care Quality Commission (CQC) inspection on 05 and 06 October 2016, the service was rated 'Good' in the Caring and Responsive domains: 'Requires improvement' in Safe, Effective and Well Led domains. The overall judgement rating for the service was 'Requires Improvement' and there were five breaches of regulation. There were areas that required improvement. These included, personal emergency evacuation plans that were not in place for people to inform staff about the support they would need to leave the service in the event of an emergency; fire drills had not been completed as required; maximum hot water temperatures, set by the Health and Safety Executive were marginally exceeded. Although checks had identified this, action had not been taken to rectify it; local authority safeguarding protocols had not always been followed; some 'as and when needed' medicines were administered, staff had not always recorded the quantity given; applications to meet the requirements of the Deprivation of Liberty Safeguards had not been made as needed., and quality monitoring systems were in place, but were not effective enough to enable the service to highlight the issues raised at the last inspection.

At this inspection, we found that improvements have been made.

Systems were in place to enable the provider to assess, monitor and improve the quality and safety of the service and these were being followed.

Effective procedures were in place to keep people safe from abuse and mistreatment.

The registered manager had applied the principles of MCA 2005 within the service in a person centred manner which involved people in decisions about meeting their needs effectively.

Medicines were managed safely and people received them as prescribed, including as and when required medicines.

Each care plan now contained information of an individual Personal Emergency Evacuation Plan (PEEP). The fire safety procedures had been reviewed and were regularly monitored in line with the provider's policy. A water management plan was in place to reduce the risks

This service had a registered manager in post. A registered manager is a person who is 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 registered manager was also responsible for looking after other services owned by the same provider. Although always in contact with staff, when the registered manager was not present at the Littlecroft sites, team leaders oversaw the running of the service.

Most people were able to indicate to us they liked living in the services, they appeared happy, relaxed and contented in a comfortable living environment, interacting readily with staff and without hesitation.

There were enough staff to keep people safe. The registered manager continued to have appropriate arrangements in place to ensure there were always enough staff on shift.

Staff knew what their responsibilities were in relation to keeping people safe from the risk of abuse. Staff recognised the signs of abuse and what to look out for.

Staff received regular training and supervision to help them to meet people's needs effectively.

Healthcare needs had been assessed and addressed. People had regular appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists to help them maintain their health and well-being.

People were supported to eat and drink enough to meet their needs.

Staff treated people with kindness and respect for their privacy and dignity. Staff knew people well and remembered the things that were important to them so that they received person-centred care.

People had been involved in their care planning and care plans recorded the ways in which they liked their support to be given. Bedrooms were personalised and people's preferences were respected.

Independence was encouraged so that people were able to help themselves as much as possible.

Staff encouraged people to actively participate in activities, pursue their interests and to maintain relationships with people that mattered to them.

The registered manager ensured the complaints procedure was made available in an accessible format if people wished to make a complaint. Regular checks and reviews of the home continued to be made to ensure people experienced good quality safe care and support.

The registered manager provided good leadership. They checked staff were focused on people experiencing good quality care and support.

The provider had a set of values, which included treating everyone as an individual, working together as an inclusive team and respecting each other. Staff were aware of these and they were followed through into practice.

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.

There were enough staff to safely support people, and there was guidance in place and followed by staff to ensure people's safety.

Potential risks to people's health and welfare were acted on.

Checks were in place so only suitable staff were employed.

People were supported by staff who had received training and understood their responsibilities in relation to safeguarding.

People's medicines were administered by trained competent staff.

Is the service effective?

Good

The service was effective.

Referrals had been made to a supervisory body to meet the requirements of Deprivation of Liberty Safeguards.

Staff received appropriate instruction and training when they first started work; on-going training ensured staff had the skills and knowledge to support the people they cared for.

Staff were provided with opportunities to meet the managers to discuss their work performance, training and development.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

Is the service caring?

Good

The service was caring.

Staff took the time needed to communicate with people and

included people in conversations. Staff spoke with people in a caring, dignified and compassionate way.

Staff knew people well and knew how they preferred to be supported.

People's privacy and dignity was maintained and respected.

Staff supported people to maintain contact with their family where possible.

Is the service responsive?

Good

The service was responsive.

People's care and support was planned in line with their individual care and support needs.

Staff had a good understanding of people's needs and preferences. People were supported to take part in activities that they chose.

There was a complaints system and people knew how to complain. Views from people and their relatives were taken into account and acted on.

Is the service well-led?

Good

The service was well led.

Quality assurance processes were effective to ensure required actions were identified and progressed.

Staff felt supported and there was an open culture in the home which encouraged staff and people to share their views.

Statutory notifications required by CQC were submitted when needed.

Staff were aware of their responsibilities to share any concerns about the service.

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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.

This was a comprehensive inspection, which took place on 14 February 2018 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members.

We reviewed the information we held about the service. Before the inspection, we asked 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. We looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

People's ability to communicate was limited, so we were unable to talk with everyone. The expert by experience observed staff interactions with people and observed care and support in communal areas.

We spoke with the registered manager, one team leader and four support staff.

We looked at the provider's records. These included two people's care records, which included care plans, health records, risk assessments and daily care records. We also looked at medicines administration records. We looked at two staff files, a sample of audits, staff rotas, and staff training records.

Good

Is the service safe?

Our findings

People were unable to verbally tell us about their experiences. However, we observed that people felt safe in the service and were at ease with staff. People interacted cordially with staff and the registered manager.

One staff member said, "I like working here. We work as a team. I like all the people who live here. I wouldn't change anything".

At the last inspection in October 2016, we identified breaches of Regulation 12, (Safe Care and Treatment); Regulation13, Safeguarding service users from abuse and improper treatment) and Regulation 19, Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to safely manage potential risks to people in the environment; to report safeguarding incidents to the local authority; and to implement safe recruitment procedures. A recommendation was made to review the PRN medicines procedures to conform with and reflect best practice.

At this inspection we found that improvements had been made to all identified areas.

Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training. The staff we spoke with were aware of the different types of abuse that may occur, what would constitute poor practice and what actions needed to be taken to report any suspected or actual abuse. Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of Social Services. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The service had up to date safeguarding and whistleblowing policies in place that were reviewed regularly. At this inspection, the registered manager told us that there had been no safeguarding alerts raised since the last inspection, but would ensure referral to the appropriate body when appropriate. This meant that effective procedures were in place to keep people safe from abuse and mistreatment.

People continued to be protected from avoidable harm. Staff had a good understanding of how to safely manage people's individual behaviour patterns. Care plans provided staff with detailed information about people's needs. Through talking with staff, we found they knew people well, as most staff had worked at the service for some years. They knew how to deal with any difficult situations such as behaviours that challenge staff. Behaviours that challenge are typical behaviours displayed, which may put people or others at risk, or which may prevent the use of ordinary community facilities or a normal home life. This behaviour may include aggression, self-injury, or disruptive and destructive behaviour. People were supported in accordance with their risk management plans. Staff demonstrated that they knew the support needs of the people at the service, and we observed support being delivered as planned.

Risk assessments remained specific to each person. Staff told us they were aware of people's risk assessments and guidelines were in place to support people with identified needs that could put them at risk, such as choking, and tripping and falling. People had clearly written individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. Guidance was provided to staff on how to manage identified risks. This ensured staff had all the guidance they needed to help people to remain safe.

Risk assessments were reviewed when needed and linked to accident and incident reporting processes. Accidents and incidents were comparatively low in frequency and managed in a way which protected people from the likelihood of recurrences. Staff had completed incident reports and the registered manager recorded their actions. This helped to ensure the service learned from incidents and put processes in place to reduce the risk of them happening again.

Administration of medicines was undertaken appropriately. Staff were patient and knowledgeable, they reminded people what the medicines was and explained if pills were to be chewed or swallowed with a drink. Opened medicines were dated to ensure they were not used beyond their shelf life. Where skin creams were used, charts recorded application and guidance that ensured staff knew where, how much and when the cream should be applied. Refusal of medicine was recorded and contact made with relevant health professionals if this continued. For medicines given with food, appropriate professionals had been involved and consent had been recorded as in the person's best interests. Where medicines were given with food to make them more palatable or easier to swallow, checks with the pharmacist ensured this did not alter the properties of the medicine. Staff knew how to give rescue medication for conditions such as epilepsy.

Medicine administration records (MAR) included a photograph of the person, what medicines were prescribed, what they were for and details of any possible side effects. MAR charts were completed as required. Weekly checks of medicines took place and records showed the amounts stored were correct. Any medicines no longer needed were accounted for and returned to the pharmacy for safe disposal. Protocols were in place for 'as and when required medicines' (PRN) medicines, such as paracetamol and laxatives; and at this inspection we found that PRN protocols were being followed in line with best practice. Staff were knowledgeable about when they might be needed and how to monitor people's conditions to help them interpret people's need for them.

Staffing levels were based upon people's dependency assessments and were flexible to accommodate outings, activities and accompanying people to appointments. Staffing comprised of two staff on the day shift and one sleep night member of staff per bungalow. There was an established on call system should additional support be required. Agency staff were not used, any shortfall was met by staff employed by the provider. This ensured familiarity of people's needs and enabled them to be addressed consistently and safely. People and staff felt there were enough staff on duty to support people, their activities and safety.

The provider continued to have an up to date recruitment policy in place, which enabled safe recruitment procedures to be followed. We looked at two recruitment files. These contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

We found at this inspection that each care plan contained information of an individual Personal Emergency Evacuation Plan (PEEP). For one person, it was recorded that the person was to be transferred in their wheelchair. The fire safety procedures had been reviewed and the fire log folder showed that the last fire drill was undertaken on 09/10/2018.Fire equipment was checked weekly and emergency lighting monthly.

There was a plan staff would use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies. The service had a formal strategy to ensure people received safe and continuous care in case of emergencies at sister services owned by the same provider.

Records showed the provider ensured proper checks were carried out of the electrical installation in the bungalows; the gas safety certificates were current and portable electrical appliances checked. Fire extinguishers were checked and emergency lighting regularly tested. At this inspection, we found that hot water testing and recording was being carried out. A water management plan was in place to reduce the risks of legionella, water borne bacteria, and records of shower head cleaning were being maintained.

People continued to be protected from potential cross infection. There was a cleaning system in place that allowed for daily, weekly and deep cleaning to take place. Records of cleaning were kept. Staff confirmed they understood their responsibility to assist people to maintain the cleanliness in the service. Staff received food hygiene and infection control training.

Good

Is the service effective?

Our findings

Views provided by relatives and social and health care professionals in surveys reflected that staff knew people well and understood how to communicate effectively according to individual needs.

People were unguarded, reacting openly and positively when supported by staff. Some people led staff to show how they wanted to be supported or what they wanted to do; other people communicated by facial expression, behaviour, mannerism, making sounds, gesturing or with a few words. Staff understood people's communication and provided informed and wholehearted support

At the last inspection in October 2016, we identified a breach of Regulations 11, (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. At this inspection we found that improvements had been made.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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 what any conditions on authorisations to deprive a person of their liberty were. This showed that the manager applied the principles of MCA 2005 within the home in a person centred manner which involved people in decisions about meeting their needs effectively.

Policies reflected if people lacked capacity where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate or Relevant Person Representative was required. These are workers who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service and best interest processes had been used in relation to dental work.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. People were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

In terms of day to day living and decisions, staff gained people's consent to give them care and support and carried this out in line with their wishes. People were involved in their day to day choices about accessing activities, spending time outside of the service, the food and drinks they had and their daily routines. Some people indicated choice by pushing away unwanted items or by leading staff to show what they wanted, hand gestures and limited verbal communication. In addition some people were able to supplement their communication with Makaton hand signs, which staff recognised and responded to. Referrals were made to speech and language therapists to help with communication difficulties.

People had individual communication plans together with cues to help staff identify distress signs in people who, because of cognitive impairment or physical illness, had severely limited communication. This included information about facial expressions, body language and gestures as well as other indicators such as people's general demeanour and what any changes may indicate. For example, how people may appear and react if they experienced pain, anxiety or were becoming frustrated. These helped to ensure effective understanding between people and staff and helped staff to recognise if people were unable to communicate their needs.

Staff were aware of people's food preferences and any specific dietary needs. One member of staff told us, "The team leader orders the food. The staff share the cooking. We give people a choice of meals. We have to puree the food for one person. Some of the people living here are able to ask for a drink if they want one". Some people went to local shops and chose what they wanted to eat. People were aware of the benefits of healthy eating and where some people needed support to lose weight, they had achieved this. There was a good choice of food; meals were varied and enjoyed. Where people had difficulties swallowing or this presented a choking risk, Speech and Language Therapist advice was sought and put into practice. Staff carefully prepared meals and drinks to required consistencies and helped those who required support to eat and drink. One staff member said, "One person has been seen by the dietician as they are very thin. We have been given advice how to add calories to their meal such as butter, and they have fortified shakes to drink. Their weight is monitored monthly".

People were supported to maintain good health and received on-going healthcare. They were registered with the local GP and had access to other health care services and professionals as required. One staff member said, "One person has regular physiotherapy, and we have been shown how to do it as well, to prevent them getting stiff." Another staff member said, "The people who live here have good access to medical services. The GP is excellent. We were concerned about one person who appeared to have poor vision and professional appointments have been made measures to have this investigated". Where specialist advice was needed, for example about people's mental health, communication or physical difficulties, we found referrals had taken place and the advice received was followed. Health action plans were based upon individual needs and included dates for medical appointments, medicine reviews and annual health checks; these had taken place when needed. Where people presented behaviour that could challenge staff or others, staff worked with health professionals to look at ways of managing the behaviour. Interventions and restraint were not used; other techniques and strategies, such as positive behaviour support and positive reinforcement strategies were used.

A comprehensive induction programme and on-going training ensured staff had the skills and knowledge needed to effectively meet people's needs. A training planner identified when training was due and when it should be refreshed. Staff received regular training in areas essential to the effective running of the service such as fire safety, first aid, infection control and food hygiene. Additional training had been delivered which helped staff support people, including epilepsy awareness as well as specific training for administration of epilepsy recovery medicines. Training provided was a mixture of computer based learning and face to face training. Staff told us the training was good quality and they felt confident to do their job properly. Staff said,

"We have regular training, such as first aid, fire safety, medicines, and dementia awareness. We can do the training online," and "There are plenty of staff here. We all get on well. We do online training such as medicines, first aid, health and safety, food hygiene, epilepsy, safeguarding and capacity".

All staff had been set objectives which were focussed on people experiencing good quality care and support which met their needs. The registered manager checked how these were being met through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff confirmed to us that they had opportunities to meet with their registered manager to discuss their work and performance through supervision meetings.

Staff communication was effective. A handover book ensured key information was passed between staff, such as GP appointments and key comments about care and support delivered. Staff told us this system worked well.

Good

Is the service caring?

Our findings

There was a pleasant atmosphere in the service, some people laughed and smiled as staff supported them. One person enjoyed the sound of moving paper. This provided visible enjoyment and reassurance for people.

Staff made time to listen to people; they were intuitive in their support, responding to individual communication cues compassionately and always with respect. Staff were considerate and courteous when supporting the people in their care. They were friendly and unhurried in their approach, giving people time to process information and communicate their responses.

There was a strong and visible person centred culture at the service. Care was planned around the individual and centred on the person. Staff knew about people's background, their preferences, likes and dislikes. Staff spent time with people to get to know them. There were descriptions of what was important to people and how to care for them in their care plan. Staff recognised where possible the importance of working well with families.

Staff were attentive. They observed and listened to what people were expressing. Pictures and photos were used to help people to make choices and communicate what they wanted. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner.

Staff were able to describe each person's support needs accurately and tell us about them as an individual and describe people's individual personalities. Records of people's days had been made and provided information about the support and care they had received, together with some photographs of what they had been doing.

Staff were aware that different people responded to different styles of support, they were consistent in the ways they supported people. For example, short sentences helped some people understand what to do, where as other people led staff to help support them with tasks; staff were always mindful of people's independence and gave them the chance to do things for themselves before stepping in or prompting if needed. Care plans included guidance for staff to support people to do as many things for themselves as they could; we observed this happening during the inspection. For example, when people were eating.

When people were at the service they could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms. People could have visitors when they wanted. People were supported to have as much contact with family and friends as they wanted to. People were supported to go and visit their families, relatives and friends. One staff member said, "Some of the people have family who come and visit them here. Sometimes it is at Christmas or on their birthday. If there are any problems we will get in touch with the family".

Staff described how they supported people with their personal care, whilst respecting their privacy and

dignity. This included explaining to people what they were doing before they carried out each personal care task. People were given support with washing and dressing if needed. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their communication needs.

People's privacy was respected. People were moving freely around the home, moving between their own private space and communal areas at ease. Staff knocked on people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discrete support with their personal care.

Staff felt the care and support provided was person centred and individual to each person. Staff had built up relationships with people and were familiar with their life stories and preferences. People's care plans told us how their religious needs would be met if they indicated they wished to practice. People's information was kept securely and staff were aware of the need for confidentiality.

Good

Is the service responsive?

Our findings

When a person moved into the service an assessment was completed. When people needed support to communicate their needs other people advocated on their behalf, for example, members of their family or someone who knew them well. People were enabled to contribute as much for themselves as possible.

Information was gathered about people's interests and about what was important to them. Staff were able to demonstrate a good understanding of the people they supported. Within people's plans were life histories, detailed guidance on communication and personal risk assessments. In addition there was specific guidance describing how the staff should support people with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. For example, 'I have a bath around 7.30pm'.

Some people had specific behavioural needs and these were well documented in their care plan. Staff showed that they were very clear about these needs and how to support them. Some people were able to say what they wanted, and staff were responsive to people if they became unsettled or unhappy about something. Staff told us care plans gave an in-depth understanding of the person and were personalised to help staff to support the person in the way that they liked.

Care plans contained information about people's individuality which was presented in a person-centred way. Care plans contained information about people's wishes and preferences and detailed guidance on people's likes and dislikes around food, drinks, activities and situations. Challenging behaviour care plans detailed what people may do, why they did it, warning signs and triggers and how best to support them.

Health action plans were also in place detailing people's health care needs and involvement of any health care professionals. Each person had a healthcare summary, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were kept up to date and reflected the care and support given to people during the inspection. People had review meetings to discuss their care and support. They invited care managers, family and staff.

Health plans contained comprehensive and specific information. This had helped to ensure specific conditions were monitored and appropriately reviewed so that the right support was provided. Specialist occupational aids were provided, for example, profiling beds and where needed epilepsy bed monitors ensured people were safe when they slept and individually designed orthopaedic wheels chairs, shoes and shoe inserts supported people with their mobility. Where people needed head protection to minimise risk of injury, this was always used, well fitted and in good condition.

Where people had specific conditions, for example, epilepsy, there was guidance for staff about symptoms or indicators which may precede a seizure and the support the person would need. Monitoring of seizures helped to inform medication reviews and to determine how well the epilepsy was managed. Health care needs were clearly recorded and contained comprehensive and specific information, including input from

health and social care specialists where necessary. This had helped to ensure that health conditions were monitored and appropriately reviewed.

People enjoyed various activities, both inside and outside of the service, these included, music, garden games, walks and outings. Some people attended an activity centre and two vehicles based at the service enabled staff to drive people to their various activities. People were supported to participate in activities of their choice, within the service and the community. We were told about past and upcoming events held at the service and sister services. One member of staff said, "A lady comes in to give the people who want one a massage once a week and the hairdresser comes in every 6 weeks or so to cut peoples' hair." Another member of staff said, "They do cooking, go bowling, shopping, go out into the community. Sometimes we see them when they are out and about with the people from the day centre."

The service's complaints procedure was available in pictorial form; it was clear and included both verbal and written complaints. There were no complaints at the time of our inspection. Staff clearly explained how they would support people to make a complaint if the need arose. In a recent survey, a relative had commented, 'Thank you for caring'.

Good

Is the service well-led?

Our findings

The service had a registered manager who was supported by team leaders and support workers. They had recently been registered by the Commission as manager of this service but also worked as the registered manager at sister services. The registered manager explained that they split their time equally between the services they managed, although if one service needed more input at a particular time, they would spend more time there. Staff and people were positive about the registered manager, describing them as always approachable and supportive. Staff felt the provider and registered manager listened to their opinions and took their views into account, giving examples of food quality and support needs.

Staff said, "I have worked here since 2009. I love it here", and "I have worked here since 2006. I wouldn't change anything". All the staff we spoke with said, "If I had any problems I would be happy to talk to the manager".

At the last inspection in October 2016, we identified breaches of Regulations 17, (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of the service. At this inspection we found that improvements had been made.

The registered manager and provider undertook regular checks of the service to make sure it was safe and remained serviceable. Environmental risk assessments were reviewed and up to date. Personal emergency evacuation plans were in place and fire drills had been carried out and recorded. Water temperatures were being controlled, tested and recorded. Recruitment procedures had been reviewed and met the required standard.

Established systems sought the views of people, relatives, staff and health and social care professionals and had been undertaken for the current year. Questions covered areas such as staffing, choices, feeling safe and being listened to, and the responses were positive overall. The service had a variety of methods by which to measure the standard of care and people's experiences of it, including one to one meetings and discussions with people's families.

The registered manager and all staff demonstrated a good knowledge of people's needs and spoke with passion when talking to us about supporting people. During the inspection we observed that people engaged well with the registered manager who was open and approachable. Staff had delegated responsibility for health and safety, doing daily allocated jobs and attending training courses. They were clear about their role and responsibilities and were confident throughout the inspection.

The registered manager made sure that staff were kept informed about people's care needs and about any other issues. Staff handovers and team meetings were used to update staff regularly on people's changing needs. There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. There was a positive and open culture between people, staff and management. Through our observations at

inspection it was clear that there was a good team work ethic and that staff felt committed to providing a good quality of life to people.

The visions and values of the organisation were putting people first, being a family, acting with integrity, being positive and striving for excellence, the registered manager and staff were clear about the aims and visions of the service. People were at the centre of the service and everything revolved around their needs and what they wanted. When staff spoke about people, they were clear about putting people first.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the entrance to the service and on their website.