Parkcare Homes (No.2) Limited

Turketel Road

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 was unannounced and took place on 30 March 2017. The service provides care and accommodation for six people with learning disabilities. People have their own bedrooms located on the first floor. Communal areas are located on the ground floor but the service is unsuitable for those with mobility issues that affect their use of stairs.

We previously inspected this service in January 2016 and found breaches in legislation regarding the supervision of staff, management and security of medicines, management of complaints and the effectiveness of quality monitoring. We asked the provider to send us action plans of how they intended to address these shortfalls; which they did. This inspection was to review that the actions taken had been sustained as well as to undertake a comprehensive inspection of the whole service.

There was a registered manager in post who was available in the service Monday to Friday and was included in a telephone on call rota at weekends and out of hours to advise staff if needed. 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.

We checked previous shortfalls and found that medicines were managed well and previous concerns regarding security, storage and handwritten changes on medicine administration records had been addressed. Complaints were handled sensitively and a detailed record made of the action taken. Staff felt supported and listened to. There were improved opportunities for staff to meet with their supervisors individually to discuss development and training and an appraisal system was in place. Staff meetings were comprehensive and held more regularly. The comprehensive audit system to monitor service quality was working well and implemented more robustly to identify and address shortfalls.

All safety checks and tests of equipment and installations were routinely completed. There were enough skilled staff to support people every day to lead a fuller life. Safe recruitment procedures helped to ensure the suitability of new staff. New staff were inducted into their role and received appropriate training for this. All staff received regular mandatory and specialist training to ensure they had the skills and knowledge to support people appropriately and safely. Staff understood how to keep people safe and protect them from harm from others or in emergency situations.

People's mental capacity was assessed and there was a clear culture of least restrictive practice. People were encouraged and enabled by staff to make every day basic care and support decisions for themselves but staff understood and were working to the principles of the Mental Capacity Act (MCA) 2005. The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for themselves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

which applies to care homes. A DoLS authorisation was in place for all the people supported; these were reviewed and kept updated. The registered manager had a clear understanding of the criteria for making an application and ensured the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Risks were appropriately assessed to ensure measures implemented kept people safe. Strategies were in place to guide staff in their support of people whose anxiety affected their behaviour from time to time. People were supported and enabled to develop their independence and learn new things within the limitations of their abilities and at a pace to suit them.

People's needs were placed at the centre of the service. Relatives were able to contribute their thoughts and views through reviews, surveys and informal discussion. People were treated with dignity and respect. Staff understood people's methods of communication. Staff interactions with people were gentle, patient and respectful. People could not use the complaints procedure but staff understood how they expressed their sadness and unhappiness and would look for the causes of this.

People chose for themselves each day what they wanted to eat. Staff encouraged them to eat healthily where possible but respected peoples choices where this may not be the case. People's health and wellbeing was monitored closely and referrals were made to health professionals as and when required. People were supported to maintain their relationships with the important people in their lives. An individualised activity planner was in place for each person based on their interests and preferences; staff supported people with regular opportunities to attend activities outside the home.

The provider ensured policies and procedures guiding the support of staff were kept updated. The Care Quality Commission was appropriately notified of events that occurred in the service.

We have made one recommendation:

We recommend that the provider seeks out a competent person to install a door guard as per a previous fire risk recommendation to ensure as far as possible fire arrangements are not compromised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed well. There was good staff continuity and enough staff on duty with the right knowledge and skills. The recruitment process ensured checks were made of staff suitability.

Staff understood how to keep people safe from harm and risks were appropriately assessed. Staff took appropriate action and understood the reporting process for when incidents and accidents occurred.

The premises were clean and well maintained; servicing and checks were undertaken when required. Emergency procedures in the event of fire or other events were in place and staff were provided with out of hours support.

Is the service effective?

Good

The service was effective.

Systems were in place to ensure staff received the right induction and training for their role and could discuss their training and development needs, staff felt supported and listened to.

Staff understood people's methods of communication and knew how to support them when they expressed anxiety through behaviour. People were supported in line with the principles of the Mental Capacity Act 2005; people were helped by staff to make decisions and choices and these were respected.

Staff understood people's health needs and requirements and supported them with health appointments. Staff understood people's food preferences and included these in the meals offered.

Is the service caring?

Good

The service was caring.

All staff were committed to providing a strong and visible person-

centred culture. People's relationships with staff were positive and supportive

and provided people with opportunities to live a fulfilling life.

Staff had developed a good knowledge and understanding of each person's needs and how they made these known.

Staff respected and valued people in the way they responded to them, they were discreet in their support of people's privacy and dignity and supported them to maintain the important relationships in their lives and to make new ones.

Is the service responsive?

Good

The service was responsive

A complaints procedure was in place but people lacked capacity to use it. Staff understood however, how people expressed their sadness and unhappiness and would look for causes for this when they became aware of it.
A comprehensive system was in place for the assessment and transition of new people to the service to ensure their needs could be met. Detailed care and support plans informed staff about people's needs and wishes and guided staff support.

People were provided with opportunities for activity and stimulation inside and out of the service, activity planners were tailored to people's individual preferences. Staff monitored people's level of interest and offered alternatives.

Is the service well-led?

Good

The service was well led

Staff said the registered manager was approachable, supportive and easy to talk with. Staff had opportunities to express their views through individual and group meetings; they felt listened to and able to influence change.

A range of established audits were in place for the assessment and monitoring of quality by staff, the registered manager and the provider. Actions were taken to address shortfalls and make improvement.

Relatives and staff were surveyed for their views. Updated policies and procedures were in place to guide staff support.

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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 inspection took place on the 30 March 2017. The inspection was unannounced and was conducted by one inspector.

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 all the other information we held about the service, including previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We met five of the six people that lived in the service during the course of the inspection as one person had gone on a home visit. All of the people using the service were unable to speak with us directly about their views of the service, so we used a number of different methods to help us understand their experiences including the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

In the registered managers absence we spoke with a registered manager from another service that was providing oversight, the deputy manager, a team leader and four care staff. We received feedback from three social care professionals who raised no concerns about the service. Relatives were offered the opportunity to speak with us if they wished to.

We looked at care and support plans for three people, activity planners, health records, and individual risk assessments. We looked at medicine records, menus, and operational records for the service including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance audits.

Good

Is the service safe?

Our findings

People received one to one support every day; staff were mindful of their responsibilities to provide this level of support and were attentive to the whereabouts and needs of the people they were supporting to help keep them safe from potential risks.

At the previous inspection we had raised concerns about the storage and security of medicines. The provider sent us an action plan to tell us of the improvements they had made and we checked at this inspection that improvements had been sustained. Since the last inspection staff told us that a protocol was now in place that the window of the medicines room where medicine stock was kept was to be locked when the room was unoccupied. A frosted film over the window had reduced the likelihood of risks of strangers identifying the presence of medicines. Prescribed creams were now separated into different containers from oral medicines and staff were aware of the need to rotate stock and dispose of out of date medicines.

It was still the case that only trained staff undertook medicines administration, their training was updated and their competency assessed by the registered manager. Senior staff undertook all aspects of medicine management and satisfactory arrangements were in place for the ordering, receipt, and disposal of medicines. In addition to the main stock of medicines peoples individual 'in use' medicines were kept in their bedrooms in locked cabinets; people did not have capacity to administer their own medicines but this afforded them greater privacy and dignity when receiving their medicines. Medicine storage areas viewed were clean, tidy and temperatures recorded to ensure these did not impact on the effectiveness of some temperature sensitive medicines. A review of medicine records showed that a photograph of each person was provided with each individual medicine record to ensure the right medicine was administered to the right person. Two staff were now required to countersign any changes to prescribing instructions on medicine records and this provided an audit trail; medicine records viewed were completed appropriately.

Since the last inspection the frequency of fire drills had increased to monthly, the initials of staff attending were now recorded and the deputy manager was aware of the need to ensure all staff had attended a minimum number of drills each year. As a result of our previous inspection people's personal evacuation plans (PEEPS) had been reviewed. PEEPS record people's individual needs to ensure a safe evacuation and sets out specific physical and communication requirements that each person has. These guide staff in helping people evacuate safely from the service in the event of a fire. Staff knew how to protect people in the event of fire as they had undertaken fire training. In the a previous fire risk assessment it was recommended that a door guard be fitted to one person's bedroom. Door guards are fire safety equipment, and are designed to close automatically in case of fire to prevent its spread . Staff told us that people were sometimes resistant to changes in their environment, however this was a matter of safety and needed to be implemented.

We recommend that the provider seeks out a competent person to install a door guard as per a previous fire risk recommendation to ensure as far as possible fire arrangements are not compromised.

Checks, tests and servicing of fire safety systems and equipment were made regularly and recorded. Staff

had access to emergency out of hours support numbers if they needed management advice or guidance.

People were provided with a clean, tidy and comfortable home. Staff felt there was good investment in the service and repairs, maintenance and requests for replacement furnishing was carried out in a timely way. People were provided with a secure accessible garden for their use. Servicing of gas, electrical installations and portable electrical appliances were regularly carried out to ensure they were safe and in good working order. Improvements identified previously by the registered manager and senior staff regarding the adequacy of laundry facilities had now been addressed. A new washing machine capable of providing a sluice facility for managing soiled laundry was now in place. Staff had received training in infection control; they understood about managing soiled laundry and were provided with appropriate protective clothing and equipment to maintain good standards of infection control.

We were informed that the registered manager remained the safeguarding lead for the service; this meant that she had received enhanced training to be able to cascade and deliver safeguarding training to staff. All staff received safeguarding training and this was kept updated. In discussion staff were able to demonstrate they understood the different forms abuse could take and were confident of reporting concerns. Newer staff were less familiar with what external agencies they could raise alerts with; we had no concerns however that they would not take action because they said they would re-read the policy to check what else they could do if they received an unsatisfactory response from within the organisation. We did discuss with the deputy manager what else could be done to further embed staff awareness of external agencies and their role in the safeguarding process. The provider had in addition to training made policy information available and a flow chart was located in several areas around the service that made clear the process staff should follow should they suspect abuse. The deputy manager took immediate action to signpost this information again via a memo that also required staff to re-read the policy to refresh their knowledge.

People lacked capacity to recognise when they could be in danger and at risk or could pose a risk to others. Each person had a range of individualised risk assessments developed specifically to address the risk they could experience from their environment or as a consequence of health or emotional anxieties. To help ensure people were protected, measures were put in place to reduce the level of risk they might experience inside and outside of the service, for example when outside the service, using public transport, or risks associated with health and medical treatment, behaviour, personal care routines or activities. Risk assessment information was comprehensive and was kept updated and reviewed on a regular basis in response to changes.

Environmental risk assessments had been developed; these were also reviewed regularly and updated in response to changes. People were closely monitiored by staff but we identified that it would be good practice to remove bathplugs from bathrooms until people were having a bath, this reduced the risk of people running a bath unsupervised. A risk assessment was completed during the inspection and bath plugs removed to secure locations. Environment risk assessments informed and guided staff practice in the event of emergencies some of which might require the evacuation of the building. An overarching emergency plan was in place; this informed staff of the actions they needed to take in the event of a range of emergencies that could impact on the running of the service.

Staff appropriately reported accidents and incidents that occurred inside and outside the service to the people they supported. In general people experienced few personal accidents but some people experienced a number of incidents usually linked to behaviour and how they expressed their emotional anxieties; these could on occasion impact on others. Staff were offered debriefing for some incidents and the registered manager and senior managers monitored the frequency and type of incidents for trends or patterns. A review of support plans, behaviour strategies and risk information would also be undertaken if necessary

and in some cases referrals to other professionals to help in managing better and reducing frequency of similar occurrences.

The provider operated safe recruitment procedures. These helped them make safer recruitment decisions and prevent unsuitable people from working with people who use care and support services. Staff records were well ordered and information easy to find. Important checks and information such as criminal record checks through the Disclosure and Barring Service (DBS), conduct in employment and character references, health declarations and evidence of personal identity including a photograph were all in place. We noted minor omissions in employment histories on two staff files viewed and this was addressed at inspection.

The staffing rota showed that there were enough staff to ensure people received one to one support and this was reflected on the day of inspection. The registered manager worked office hours Monday to Friday although occasionally undertook unannounced visits at other times. The deputy manager worked on shift and shifts operated between 7:30 am to 2:30 pm and 2:30 pm to 9:30 pm after which time there were two waking night staff during the hours of 9:30 pm and 7:30 am. Some staff were specifically allocated day care duties to be available to support 2:1 activities outside the service or to work with people in the house; these additional hours supplemented staffing levels throughout the week. This meant that there were enough staff to provide each person with individual personal support and activity during the day. Staff said they were happy with staffing levels.

Good

Is the service effective?

Our findings

Although at times it could be noisy with lots of activity going on, in general people were relaxed and comfortable in their daily routines. Staff knew people well. Staff were observed interacting with people using the communication methods that they were familiar with and preferred. Staff were seen to offer people choices. Staff understood people sufficiently well to know when it was appropriate to give them space away from others.

At the previous inspection although staff had told us that they felt supported, opportunities for them to receive one to one meetings (supervision) with their supervisor had become less frequent; these meetings allowed staff time to discuss their performance training and development. This had been identified within internal audit checks as an area for improvement but had not taken place. Since then staff told us supervision frequencies had improved. A supervision schedule was now in place that showed staff were receiving regular supervision approximately every 6-8 weeks. A programme of annual staff appraisal was also underway for those staff in post long enough to qualify.

Handovers between shifts were undertaken between shift team leaders to ensure there were no gaps in support to individual people as staff changed over. The incoming shift leader arrived early to ensure they could undertake appropriate checks with the outgoing shift leader and this included checks of medicine records and finances. The team leader for the new shift cascaded anything staff needed to be aware of but staff also said it was always common practice to read the communication book for any information about changes they needed to be aware of.

New staff completed a company induction programme that included a four day induction and two weeks shadowing of experienced staff. The provider information return completed in January 2017 informed us that in the last 12 months three staff had completed their induction. New staff spoke positively about having this time to understand the routines of the service. They were able to get to know other staff and the people supported better; familiarising themselves with people's individual needs and how these should be met. During this time staff also completed much of their mandatory training through the organisation's 'Foundations For Growth' training programme. This provided them with the basic level of knowledge they required to undertake their role. New staff that were without previous care qualifications were required to complete the Care Certificate. This was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction period and adhere to in their daily working life.

The provider ensured that a programme of refresher training was available to experienced staff to cover mandatory areas such as safeguarding, health and safety, fire, food infection control and moving and handling. In addition other training was available in specialist areas such as autism or positive behaviour support. We were informed that if specific training needs were identified to meet the individual support needs of someone in the service then this would be sourced. The availability of this range of training helped inform staff knowledge and understanding to meet the needs of people in their care appropriately and in accordance with current best practice. Staff were supported to undertake qualification training and the

Provider Information Return completed in January 2017 informed us that 16 out of 25 staff had achieved a NVQ/Diploma at level 3. Diplomas are work based awards that are achieved through assessment and training. To achieve a diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Every service user was subject to a DoLS authorisation and these were kept updated. Staff offered people choices when providing support through pictorial prompts and signs. This helped people to make decisions on a day to day basis about for example, what they wanted to wear, what music they wanted to listen to, where they wanted to go and what they might want to eat or drink, how they were feeling. Capacity assessments were in place to inform staff what areas of their life people could and could not make decisions about for example, finance, personal care, medicines. Staff worked to the principles of the Mental Capacity Act 2005 to ensure any important care and treatment decisions were made in the person's best interests by people who knew them well.

Staff understood how people expressed their emotional anxiety sometimes through behaviour that could harm themselves or impact on others. Staff had been trained to intervene appropriately and comprehensive guidance was in place to help guide their responses. Staff understood people's moods and characters. We observed an escalation in behaviour which staff responded to by giving the person space to calm down. They showed that they were alert to changes in the person's behaviour and their prompt intervention pre-empted and de-escalated the situation.

People's food preferences were well known to staff and although they encouraged people to eat healthily they respected people's right to eat things they preferred. People ate at different times from each other and this fitted in with their own daily routine. People ate and drank different things in accordance with their own preferences and we observed staff involving people in making active choices by physically showing them different food options, and then encouraging them where appropriate to be involved in preparing their food for example buttering their toast. One person was supported to shop for food items they particularly wanted to eat which differed from the meals other people ate. Staff recorded people's food and fluid intake but no one was considered to be at risk. People's weights were recorded on a regular basis.

Each person had a health passport and a health checklist in place to ensure all aspects of their healthcare needs were kept under review including routine doctor, dental and optician appointments. Hospital passports were noted in some people's records. Staff said they kept relatives informed of any health changes. They supported people to appointments and liaised with other professionals to seek strategies for enabling people who were resistant to health checks to have their health needs assessed in the least restrictive and intrusive manner possible. The staff team had demonstrated their willingness to support someone throughout a hospital stay to ensure they remained well supported at all times and had received praise for their response from a relative and a social care professional.

Good

Is the service caring?

Our findings

We observed many positive interactions from staff towards people they supported. The availability of staff meant they had time to give to people. Routines were relaxed and people got up when they were ready and were supported with their personal care, this was undertaken discreetly. People respected each other's space.

Staff demonstrated a detailed understanding of the character and behaviour of the people they were supporting; more than 50% of staff had completed training to help them in their understanding of peoples communications needs. Staff used communication tools suited to their specific needs for example some people used the PEC system (The Picture exchange communication system) which is an alternative communication method for people with developmental difficulties. Other people had their own communication books that contained preferred pictures that they knew well and which staff used to consult with them about in their daily routine, people had Pecs's boards in their bedrooms which informed them what was happening that morning for example, bath/shower, breakfast and then a preferred activity. This was updated to reflect other periods of the day and what people might be doing then.

Staff were observed encouraging people to participate in tasks for example helping with their breakfast "X would you like to come and help me put the cheese spread on." Staff were seen offering choices to people and supporting their daily routines for example, a staff member asked us to move seat as this was usually occupied by a particular person who always sat there, they were then seen to give the person a choice of snack, when the person signalled the one they wanted they then gave a choice between two pieces of fruit. Staff were also seen to be attentive to peoples general demeanour and wellbeing, for example staff were a little concerned about someone who was up later than usual and how this might be a sign of them becoming unwell. Concerns like this were shared with other staff on the shift to be alert for any further signs.

People were comfortable with staff and found it easy to approach them for things they wanted. We observed two people coming to the office to collect their Ipad's which were kept there overnight for charging; a precautionary safety measure. People used new technology for playing games and watching YouTube and listening to music, we were informed that parental controls were in place on devices so people were not placed at risk from looking at unsuitable sites?.

Staff showed patience and kindness and were able to extend their full attention to the people they were supporting, our observations showed staff to be respectful in their attitudes towards people. Routines were relaxed and tailored to the needs of each person, people could be resistant to personal care routines combing hair, shaving or to wearing appropriate clothing. Staff ensured people dressed appropriately when out but accepted that sometimes people were resistant to wearing weather appropriate clothing. Indoors people wore casual clothing that they felt comfortable with.

People were supported by staff to maintain important relationships with their family and prompted them to mark significant dates such as family member's birthdays or anniversaries. Staff spoke positively about relatives and how much they were involved and interested in the care of their family members and how they

respected this. We read compliments and praise from a relative in regard to the great care staff had provided to one person who had undergone a hospital stay, and how supportive this had been for the family members at a difficult time; this showed good partnership working with relatives. Relatives were welcome at the service but encouraged to ring before calling in in case the person they wanted to see was out. Staff knew to inform relatives if a person was unwell or anything untoward had occurred.

Two people experienced regular home visits and days out with their families. Another person had holidays away with their parents. Staff had been proactive in arranging a holiday for another person with a sibling who was located in another service, this had worked well and staff hoped to repeat this perhaps involving another family member so they could holiday together for the first time ever. Other people were unable cope with changes in their routine that would enable them to travel away on holiday and so staff provided special days out for them.

When at home people were able to choose where they spent their time, for example, in their bedroom or the communal areas and moved freely between these spaces. Individual bedrooms were personalised with possessions and family photos and décor reflected people's preferences and interests.

Good

Is the service responsive?

Our findings

People were observed being prompted by staff to engage in some of the activities they enjoyed and offered impromptu outings; or for those with scheduled activities outside the service, they were supported to get ready to go out.

At the previous inspection we had expressed concern that complaints received from relatives or from people were not always being recorded as such. We asked that action be taken to improve how complaints whether informal or formal were received, managed and responded to and the provider confirmed in their action plan that this had now happened. We noted that the policy and procedure for receiving and dealing with complaints was kept updated. The Provider information Record completed by the registered manager informed us that in the last 12 months the service had received 12 compliments and one complaint. We had no feedback from relatives or other stakeholders to suggest that further complaints had been made or were not being handled appropriately.

We checked the complaint record and noted that the complaint received had been handled sensitively and in person with a follow up response sent to the complainant. Staff understood how people used sign, body language or their general mood, behaviour and demeanour to show that they were unhappy or sad and recorded this in their daily reports and would seek to find the source of any distress or behaviour and try to address this.

No one new had been admitted to the service since the last inspection. At that inspection we looked thoroughly at the pre-admission process for new people and were satisfied that there was a comprehensive process in place for the assessment, and transition of new people into the service. This included gathering additional information from relatives care managers and previous care providers. This helped to inform the assessment process to ensure needs could be met. Assessment also and took into account and gave consideration to the impact of any new person on the existing people in the service; before final decisions on admission were made.

Each person had a detailed plan of care that guided staff in the daily support they needed to provide for each assessed need. For example in regard to communication, finance, social interaction, behaviour, day and night routines. Staff supported people to maximise their skills and levels of independence to suit their level of ability; small achievable goals and aspirations were set for people to work towards. Staff supported people to make everyday choices and decisions and respected these, for example what they wore, what they ate, what they did. People's day to day care needs were very settled and their routines well established but when needs changed care records were updated and risks reviewed.

In discussion and from our observation staff showed themselves to be knowledgeable about people's individual needs and how they liked to be supported. Staff kept detailed daily reports of each person's wellbeing covering what they had eaten and activities they had participated in. Changes in people's care and treatment were discussed with their relatives and representatives before these were put into place. Each month key workers met with the people they supported to review their care plan and involve them as

much as they were able to. Staff also reviewed and updated health information. Whenever possible relatives were encouraged to participate in meetings or read care plans if they had time to do so and comment. Individual care plans were reviewed on a regular basis. People were also reviewed from time to time by their funding authority to confirm the placement was still appropriate.

Each person had an activity planner for the week. This was developed from staff learning from relatives and from observing what interested and stimulated people. This included what people liked to do when outside the service, for example using computer time at the library, going for walks, using public transport, shopping trips. Activity planners were used as a guide for staff and could be used flexibly. Activities could be switched around dependent on each person's mood on the day, level of participation and whether there were any emerging risks. Planners and daily reports showed that people could have an activity outside the service every day or two or three times per week dependent on their personal preferences and need. Staff monitored people's level of participation with each activity. This informed them whether the person was no longer interested and it was no longer a preferred activity; in which case a suitable alternative was found. People had personal time within their planners when they could do in house activities of their own choice for example, watching favourite films or listening to music.

Good

Is the service well-led?

Our findings

Three social care professionals we spoke with expressed no concerns about the service. One told us "They have an experienced manager in place and when I last visited in they had sufficient staff to deliver the 1:1 provision, with every person having a designated member of staff and additional cover brought in during the day to deliver the 2:1 support. People received person centred care and accessed the local community." Another said "I have no concerns and they did an excellent job of supporting x when he was in hospital, my only criticisms would be that communication and paperwork could be better, other than that care is generally good."

At our previous inspection we expressed concern that the quality assurance systems in place had not been effective in identifying some of the shortfalls we had identified at inspection, we asked the provider to take action to address this which they have done. We looked at the audits and checks undertaken. Some of the daily and monthly checks were delegated to staff and their completion was checked by the team leader on shift. Team leaders also had their own checks to make each day to ensure tasks had been completed. Shift handovers included checks of the cash float for the service, people's individual monies and that medication administration records had been completed. Audits were also undertaken of vehicles, health and safety, environment checks, infection control, medicines, catering, care plan and safeguarding, any issues identified from these audits requiring action to be taken were added to the service development plan. Time scales for completion were agreed and this was monitored with the registered manager by their senior line manager.

The provider had an established compliance team and they visited every 12-18 months dependent on the needs of the service, the provider used external assessors to undertake financial and health and safety audits. This inspection highlighted no breaches of regulations. We consider that the remedial action taken by the provider to ensure the daily, weekly monthly, quarterly and six monthly audits were undertaken more robustly was working better. As a result the provider and registered manager were in a much better position to assure themselves about service quality and highlight for themselves shortfalls in the service and address them. Based on the findings of this inspection the present audit processes were working well.

There had been some significant restructuring within the organisation and staff said they had been kept informed by their registered manager about this and what impact there might be for them. Staff said they found the registered manager very approachable and personally supportive to them. Staff said the registered manager operated an open door policy but there were boundaries and they were aware of when they could not interrupt her.

Staff were happy that staff meetings were more regular and that although there had been turnover of staff the team was settling and beginning to 'gel' together. Staff thought that other staff were generally supportive and everyone helped each other out. A review of staff team meeting minutes showed these to be comprehensive, providing evidence of staff being able to discuss support strategies for individuals, issues relating to food quality, infection control, staff training opportunities, discussions around risk, and also opportunities to discuss feedback from audits and from staff surveys. The registered manager also shared the positive comments made by staff in their survey responses about what they liked about working at

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The system was in place that relatives would be surveyed directly from head office and their responses along with those of relatives for people in other homes aggregated together. This informed the provider of trends and themes that were emerging and might need action to be taken. Informal arrangements were in place for relatives to receive and give information about their family member or general issues relating to service quality.

The provider information return (PIR) was returned on time as requested. This informed us about the actions taken by the provider to improve the service since the last inspection and further planned improvements

Services that provide people with health and social care are required to notify the Care Quality Commission (CQC) of important events that happen. The manager ensured that they reported notifiable incidents to the commission when required.

Policies and procedures that guided staff practice were kept updated for staff to reference.