Consensus Support Services Limited

The Gables

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 Gables is registered to provide accommodation for up to 16 people who require nursing and person care including those living with dementia, Autistim or with a learning disability. There were twelve people using the service when we inspected.

This unannounced inspection took place on 25 May 2016.

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 been trained in, and were knowledgeable about, protecting people from harm.

A process and checks were in place to help ensure that staff's suitability to work with people living at the service was to an appropriate standard. There was a sufficient number of suitably qualified and experienced staff to support people and meet their needs.

Staff were trained in medicines administration and they had their competence to do this regularly assessed. Only those staff deemed competent were then duly authorised to safely administer people's prescribed medicines. People's medicines were managed safely.

Risk assessments were in place to help manage each person's assessed health risks. Staff used positive behaviour techniques to support people with behaviours which could challenge others.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service's registered manager and staff were knowledgeable about when an assessment of people's mental capacity was required. Staff were aware of the circumstances and conditions when an application to lawfully deprive any person of their liberty was required. Appropriate applications had been made and these had been acknowledged to lawfully deprive some people of their liberty.

Staff were regularly supported with both formal and day to day supervision. This was to develop their skills, increase their knowledge and help determine the most appropriate qualifications for their role.

People's care was provided with compassion and in consideration of each person's assessed needs. People were supported to improve their independent living skills by staff who knew the people they cared for well.

People were supported by staff with the person's preferred means of communication. Relatives, nursing and care staff, health care professionals and social workers contributed to people's to the assessment of

people's care needs. People's care plans were in a format that promoted people to be as involved, as much as possible, in planning and determining their care needs and levels of independence.

People were supported and encouraged to access a wide range of health care professionals including dieticians, speech and language therapists and GP services. Staff's adherence to the advice and guidance provided by health care professionals had a positive impact on people's lives.

People were supported to eat and drink in a safe way and they were encouraged to eat and drink sufficient quantities to achieve a healthy and balanced diet. A choice of meal options were available and staff knew people's preferred times and places to eat.

There were missed opportunities for people's social stimulation including hobbies and interests. The registered manager adopted a proactive approach in dealing with and managing concerns that had been raised. Staff knew when people were happy with their care.

The provider and registered manager had effective audits and quality assurance procedures in place. Information gathered from audits was used to identify what worked well and what did not work quite so well. Improvements made were consistent and sustained.

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.

Staff had a good and confident level of understanding about how to protect people from harm. Safe medicines administration and management practice was adhered to.

People were supported by a sufficient number of suitably trained and qualified staff to safely meet people's needs.

Risks to people using the service were identified and managed in a way that gave people control over the risks they could take.

Is the service effective?

Good

The service was effective.

People were only deprived of their liberty where this was lawful. People's decisions were respected.

Staff were mentored in the role they performed and were supported to gain additional health care related qualifications.

People's health and nutritional support needs were met.

Is the service caring?

Good

The service was caring.

People were provided with care that gave compassionate consideration to the finer points of people's lives.

People had the privacy they needed and they were cared for with dignity.

People could be as independent as they wanted to be and had control over the support they needed.

Is the service responsive?

Good

The service was responsive.

People were to undertake those hobbies, interests and aspects of their lives that were important do them.

Concerns and complaints were acted upon.

Is the service well-led?

Good

The service was well-led.

Robust quality assurance procedures and monitoring of staff's performance helped drive continual improvement.

The registered manager kept themselves aware of current care and best practice in many areas of care.

All staff embraced a positive and open culture of working as a team and putting people first and foremost.

The Gables

Detailed findings

Background to this inspection

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

This announced inspection took place on 25 May 2016 and was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and information we hold about the service. Before the inspection we also looked at the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with four people who used the service, the registered manager, two nurses and two members of care staff. We also spoke with the chef.

We used 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. Not everyone was able to speak with us. This was due to some people's complex health needs. We also observed people's general care to assist us in understanding the quality of care people received.

We looked at three people's care records, records of meetings attended by people who used the service and staff. We also looked at medicine administration records and records in relation to the management of the service such as checks on matters affecting people's health and safety. We also looked at staff recruitment, supervision and appraisal process records, staff training records, and compliments and quality assurance records.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe. One person said, "I can only have food in a certain way and they [staff] make sure I stick to this." They added, "If I ask for them [staff] they come quickly on most occasions." We saw that if staff were busy helping another person they explained that they would not be long. Another person told us, "I spend the morning in my room, then the girls [staff] get me up in the afternoon and I go into the lounge in my wheelchair. They [staff] have to hoist me. It is not electric, but I feel quite safe."

We saw that staff's knowledge and understanding of what people said or were communicating such as with the use of picture cards or body language had a positive impact on people's safety. For example, knowing when it was or wasn't safe to provided people's care. One staff told us, "I know that [name] can have moments where they choose not to be cared for. If we give them 10 minutes, leave their room and come back they are then generally in a position to be cared for. I know when it is safe." This meant that any concerns about people's safety would be recognised and acted upon.

Staff had been trained in recognising, and they were knowledgeable about, protecting people from harm or the risk of this occurring. This included recognising if a person was exhibiting signs or symptoms to show that they were not their usual selves. Staff were confident that people were kept as safe as possible. One staff member told us, "We get training on techniques to de-escalate situations as well as knowing what the triggers were for people's behaviours. Knowing what these are means people are much calmer and safer." We sat in on a staff shift handover. This was an occasion where each person's care and safety was discussed. One nurse added, "[Name] has not been their usual self. We will need to keep an eye on them as it is a sign of a potential [health condition]." One person showed us how their call system worked and how quickly staff responded as a result. This showed us that staff frequently considered and acted upon the safety of the people they cared for.

We observed that people were able to take risks such as going out shopping, accessing the community, going to a day centre or attending educational establishments. Risk assessments that were in place helped ensure that people were supported and cared for in the safest way practicable. Where people required more than one staff member to support them safely with any moving we saw that this was provided. Care plans contained the level of detail that staff required, with their training on moving and handling, to keep people safe. Other measures that were in place included plans and procedures to support people in the event of an emergency. This included fire alarm tests and drills to ensure these emergency procedures worked well.

Accidents and incidents were recorded and responded to. This included where people had fallen or experienced an injury as well as where people had behaviours which could challenge others. We saw that actions had been taken to prevent or reduce as far as practicable the potential for any recurrences. As well as records of the incidences of people's behaviours, strategies were in place to support people in a safe way such as by avoiding those situations which could trigger a person's anxieties. For example, by avoiding people that the person was not familiar with. We saw that people were cared for and supported in a way which considered any anxieties that they may have had as well as how to maintain a calm and relaxed

environment.

We found that the checks completed prior to staff commencing work at the service helped ensure that only suitable staff were offered employment. Staff told us and they described the various documentation that the provider had requested from them. These documents included a recent photographic identity such as a passport, a satisfactory check for any unacceptable criminal records [Disclosure and Barring Service [DBS]] check and an employment or educational establishment records check. One care staff said, "I had to have a DBS check and my interview was over two days. This was to ensure that I had the right reasons for working here [the service]. Although I had a comprehensive induction that was only the start. I learn something every day. I had to produce my [evidence of] qualifications." The provider's recruitment procedures ensured that staff were recruited in a safe way.

The registered manager told us, "I am lucky that staff turnover is low. When we get new staff I know that the recruitment process helps ensure that only those staff who are keen to work with people with a learning disability or people with complex care needs are offered employment." This showed us that the registered manager considered people's safety.

During our inspection we saw that people's health and care needs were met by a sufficient number of suitably qualified staff. Although some people told us that they felt that there were sometimes not enough staff we found that response to people's request for assistance were no more than a few minutes. One member of staff told us, "It [staffing] is alright. It can be busy in a morning but we all pitch and help. If other staff have to be called in it is only regular bank staff. I do work some extra shifts when these are available." Other arrangements for planned or unplanned staff absence such as sickness included opportunities for over time or extra shifts.

Our observations of people being supported or assisted with moving showed us that this was done in an unhurried manner and in consideration of people's safety. For example, by staff making sure people were safely positioned in any hoist or mobility devices. These included the person's wheelchair as well as repositioning people who were at an increased risk of developing a pressure sore. One nursing staff told us, "We do have time to care for people and give them the health care they need. I have never had an occasion where I felt that we were understaffed."

Staff had been trained in the safe administration of people's medicines and they were assessed as being competent over three sessions. This was to ensure that staff administered medicines safely. We observed medicines administration and we saw that staff adhered to safe administration practice. For example, with accurate recording, accounting for the quantities of medicines held and administered and for those people who needed to be administered their medicines in a non-oral way such as creams and eye drops as well as through a tube into the person's stomach. This is known as a Percutaneous endoscopic gastrostomy [PEG].

Where medicines had to be administered when required [PRN], protocols were in place for this such as for when a person was out in the community. However, on two occasions we found that the protocols for people's PRN medicines were not as prescribed. One protocol for a PRN medicine was recorded in a liquid and not tablet form and another included a dose twice as much as prescribed. This put people at risk of being administered medicines that exceed the stated dose or medicines that were not in the right format such as soluble or non-soluble. The registered manager assured us that they would address these anomalies straight away. In addition, records and staff confirmed that neither of these medicines had been administered. We found that medicines administration records (MAR) included people's allergies and how and when they liked to take their prescribed medicines. All medicines were stored securely. Unwanted or unused medicines were disposed of safely and accurately accounted for.

Good

Is the service effective?

Our findings

Our observations of people's care showed us that staff member's knowledge about each person that they cared for had a positive impact to the person. All care and nursing staff had a thorough knowledge about the people they cared for including that for those people with behaviours which could challenge others. This included being aware of those situations which could trigger a person's behaviours. For example, knowing when it was a good time to approach the person as well as when the person needed time on their own. This had resulted in a calm atmosphere throughout our inspection and had helped keep people as anxiety free as possible. One person told us, "They [staff] know me ever so well. I have been here [at the service] for a few years now and I don't need to tell staff what to do. They always ask but this is out of politeness."

Each person was supported by a key member of care and nursing staff. This helped staff and people get to know each other well. These members of staff had an individual responsibility for aspects of the person's care such as keeping care plans and people's records accurate and up-to-date. As well as verbal skills, staff used objects of reference and people's body language and general well-being to judge how well people were. For example, knowing the individual way that the person communicated their wishes and as a way of recognising what people were telling or indicating to them. One staff member said, "As a result of my training in communicating in a non-spoken way such as [name of system] I use signs and symbols which people are familiar with. I sat down one evening with one person until I had a good understanding of the person's needs." One person told us, "Staff are very good and communication is good. I know when I am going out as well as when meals and doctors' appointments are."

The registered manager explained to us the systems in pace to support their staff. This included regular training, the 'Care Certificate' [this is a nationally recognised qualification in the standards of care to be provided], mentoring and supervision. This gave the registered manager several opportunities to develop care and nursing staff's skills. A staff member said, "If there is one really good thing about working here it is that the training is based on people's care needs. I have had stoma care, dementia care, diabetes and epilepsy training." A nursing staff told us, "I have to keep my evidence up to date and my professional registration valid." The registered manager as a registered nurse provided clinical supervision to the staff they supported. One care staff told us, "I have had a lot of training. The [registered] manager is always telling us when and what subject we need to complete. I definitely have the skills I need based upon my training."

Other more specific training included subjects such as proactive responses to people with behaviours which could challenge others, diabetes and epilepsy. This was planned to help ensure that those people living with these conditions had their care needs met in a safe way. One care staff said, "I had a really comprehensive induction and if I ever needed any support from nurses or the [registered] manager I just had to ask. Everyone has been so supportive until I have gained confidence." Training records showed us that staff completed training and refreshers for their training on a regular basis. One person told us, "Staff are very effective, they have made such a difference to my health and my life."

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.

The registered manager showed us the DoLS applications they had submitted for five people living at the service. This information had been included in people's care plans to ensure that any restrictions that had been implemented were in the least restrictive form. For example, by staff accompanying people when they went out to ensure that people were only deprived of their liberty when this was lawful. Staff were able to describe the specific decisions people could make and also where people required support with their decision making. For example, what clothes and shoes to wear. One person told us, "I can decide what I do. I need some help as I can choose what I do."

It was clear from the conversations that people had with staff and the general happy atmosphere at lunch time that mealtimes were relaxed and informal. There was a tablecloth on the table but no condiments, menu or flowers. There was little to encourage people's appetite or pleasure in their food. People were supported to eat and drink as independently as possible such as with adapted cutlery, drinking utensils and plates. We could see for ourselves that people ate those foods staff knew that people preferred as a result of a residents' meeting. The chef told us, "For some people we know what they like and don't like such as a low sugar or people who need a soft food diet. If they change their mind I always cook something else." This helped provide people with sufficient quantities of the fluids and foods that they had requested and needed.

One member of staff told us that they monitored people's fluid intake and output and encouraged people to drink more where this was needed. Records of people's nutritional and fluid intake confirmed that people had been provided with a quantity that safely met their needs.

Staff offered support to assist people to eat. For example, we heard a staff member ask one person at lunch if they wanted their pastry cutting up. The person relied 'no'. People clearly enjoyed the meal during our inspection. At the end of the meal when the person had eaten nearly everything, they said, "Thank you, that was a lovely dinner!" We also observed staff ask people if they were struggling and people responded that they weren't and that they didn't want any pudding such as one person saying, "Not today, thank you." However, no attempt was made to tempt the person with any other options such as showing them an alternative.

We saw that staff supported to people to access a range of healthcare professionals. This included attending hospital appointments. The registered manager and nursing staff told us that as part of people's dental healthcare it was usually three to four visits until the person's dental health had been fully examined. One member of staff said, "I sit with [name] as this improves their experience at the dentist and keeps them relaxed." This meant that people were supported with their healthcare needs. One nurse said, "We have a really good relationship with many health care professionals. This helps people with not just consistency but also keeping the person as anxiety free as possible." One person told us, "There is a doctor who comes every week he comes to see me each time."

Advice and guidance from various health care professionals had been sought and provided. For example, from the dietician, tissue viability nurse or speech and language therapist. We saw that this information had been included in people's care plans. Staff adhered to the advice provided such as ensuring people ate food

that had been cut into a suitable size to keep the person well. One person told us, "[Registered manager] helped me get out of hospital – I had been there for seven months. She is responsive, trying to change things." We found that the relationship that the registered manager had fostered a positive health care culture where little would get in the way of identifying and providing the right health care. For example, through the wide range of healthcare professionals they maintained regular contact with. One comment a GP had given to the registered manager was "[Name] of registered manager's clinical discussions have been very supportive and regular. I always know when the next one is".

Good

Is the service caring?

Our findings

All staff including the registered manager showed compassion for the people they cared for. The service provided care to a wide range of people including younger people with a learning difficulty as well as people living with dementia. During our observations we clearly saw the positive impact staff had on people. This was by the passion they showed and had for those people living at the service. Some of the examples we saw included staff asking people if it was "alright to move you" and "would you like to go to…". Staff did this in a way which considered the impact on the person and their well-being including when people who were not able to eat independently. While one person was sitting chatting with us just before lunch, a member of staff passed by and was greeted very warmly by the person. The staff responded, saying, "You're a pleasure to look after!"

One person told us, "The [name of staff] is very good and caring, too. [Name] is very gentle, kind and thoughtful." Staff ensured that people ate or were supported to eat in a dignified way including with the use of napkins and tabards. For example, by giving people their food in small manageable portions and allowing the person time to eat each mouthful at their pace. We observed that staff asked people discreetly where any personal was to be provided. For those people who communicated in a non-verbal way we saw staff engaged with them to include the person as much as possible in the conversation. One person told us, "They [staff] are all very caring. I need lots of care and support and they [staff] are amazing."

Some people were not able to express their feelings verbally. We saw that staff understood what the person was communicating and responded to them such as when people pointed to an object they wanted. Staff responded to people's requests sensitively and gave people time to consider their response. One person told us, "I like it here. I get on well with [registered manager] and all the staff. I am very fond of her. She cares a lot about us all. If you'd like to come here, I'd recommend it!"

We saw that people could choose if they preferred a male or female member of care or nursing staff to provide their care. People provided us with favourable comments about the difference particular members of staff had made to their lives and how caring they were. One person said, "When my [relative] could no longer cope with my care I had to come here. This is my home now and without them [staff] I couldn't manage on my own. They [staff] are always nice even when I have to be hoisted."

Staff described the circumstances they needed to be aware of to ensure at all times people's privacy and dignity was respected. This included being mindful of those situations which could cause people to become anxious. For example, by ensuring people's care needs were met in a timely manner. One person told us, "They [staff] always cover me with a towel. I am always cared for in private." We saw that at each person was offered and provided with their care in privacy and with dignity. This was by staff always closing doors and curtains as well as ensuring that when the communal bath was used that the corridors were empty and other people who liked their door open asked politely if it could be closed for a moment.

The registered manager told us and we saw in people's care records about the advocacy arrangements available and in place. This included an independent mental capacity advocate for people whose only

representative was paid staff. Advocacy is for people who can't always speak up for themselves and provides a voice for them. This meant that people who were not able to speak for themselves were supported to have their rights respected.

People's care plans were held securely and they were, when appropriate, in a format that involved the person as much as possible such as easy read and pictorial format. Care plans included what a perfect day for the person was such as relaxing in their room, watching football or a series of films. People's input also included the person's preferred means of communication such items of reference and staff's knowledge of the person and what worked best for them. Where people preferred to be involved in their care needs this was always supported by the registered manager and the staff team. One staff member said, "I am a key worker for [name] and I know the small details that can make the biggest difference such as when [name] likes to get up, go out and who they like to socialise with."

As well as people's input, family members' views and advice from health and social care professionals were included to inform the person's care plan. This was to help ensure that staff supported people with their independent living skills as well as doing this sensitively. Other methods were used to support people to be as independent as they wanted to be. This included the use of the service's transport and how this was done in consideration of the person's care needs.

Throughout our inspection we found people were cared for in a happy environment with staff and people to engage in general conversation and being able to have a laugh. One person told us, "Staff couldn't be more caring. I need a lot of it and I get the care I need." Another person said, "I am happy and I want to stay here."

People told us, staff confirmed and we saw that relatives and friends could call in to see people at any time with the person's agreement. One person said, "My [family member] comes every weekend and this is important to me. I like to catch up." In addition, relatives could take people out for a meal or a coffee.

Good

Is the service responsive?

Our findings

People's health and care needs were assessed prior to them using the service. Other information from people's life histories, relatives and staff member's knowledge of the person was also included in people's detailed care and health action plans. As part of people's on-going assessment of care needs this had resulted in the provision of various specialist chairs which had been made specifically for the person who used it. The registered manager told us, "By having these wheelchairs people can go out and do this as comfortably as possible." One person told us about the room they lived in, "It's my own personal stuff, including the shelving units full of my nick-knacks, ornaments and photos of my family. I like it a lot. The boyfriend of one of the [care staff] did it for me – two colours on the walls and a new floor. She [staff] and I went out for the day and when we got back at 6pm it was all done! I was really pleased."

Information was not always available which people could easily access. For example, on one of the noticeboards in the dining room there were weekly menus for the month. The small type size meant it was too small for anybody but the staff to read and this was at the wrong height for anyone in a wheelchair to be able to read. This limited people's ability to contribute to their care planning and needs. However, the provider submitted further evidence shortly after our inspection which showed us how people who required individual picture communications had their own tailored picture communication book, which included large pictures of a variety of foods that they liked and disliked as well as an alphabet board for the person to spell out objects or items with staff.

Activities were planned for the week such as hairdressing, flower arranging, exercise and bingo. We saw there were missed opportunities for staff to interact with people or offer social stimulation other than at meal times and medicines administration. For example, where people liked to be read their magazine or sang with. In people's care plans examples included people's favourite music or songs. One person told us, "The thing I am really interested in is music from the [Year]. I've got lots of old records in my room and when I go up there in the afternoons I like to listen to them. I'd really like some music like that down here." This was in a room adjacent to the lounge where other people's music was being played. Another person told us, "I wish the staff could spare the time to come and talk to me." And "There aren't enough activities." A third person added, "We need more outings. Every few weeks, there might be an outing. Sometimes I am able to go as well." Staff told us that there was only one person qualified to drive the service's transport and they worked part time. This limited the opportunities for people to go out as often as they wanted. We did however observe that people were provided with other occasions where their social stimulation and activities took place such as attending cookery classes, using alternatively sourced transport adapted to people's needs as well as people helping with the gardening.

Staff gave us examples of how they had introduced a new interest for a person in stages. This had been due to the person having not previously undertaken this task. After a period of time the registered manager told us that the person now "loved going out to the [place] and they can't wait to go out again". This and other similar methods provided positive results.

People were involved as much as possible in having a care plan based upon the person's individual needs.

One person told us "I go out most weeks." We saw how people who preferred to go out on a specific day to take part in their favourite pastime were enabled to do this. Care plans contained people's likes and dislikes and staff ensured that these were respected. In addition, people's care plans contained the information staff needed to be aware of such changes in a person's appearance including sudden coughing or choking and that appropriate action was taken.

Staff told us that care plans contained "the right amount of information" and how knowledgeable staff were about each person. This was evidenced by the depth of the descriptions staff gave us about each person they cared for. For example, the finer points on what was particular to the person such as going out to do what the person liked to do such as shopping. This helped to ensure that the staff were able to respond to, and safely meet what people actually wanted. Our observations showed us that staff knew each person well and responded to their needs. We saw that staff provided and met people's care needs but their social stimulation was limited. The registered manager was in the process of implementing improvements in this area to provide additional stimulation.

We saw and found that any concerns or complaints raised by people and their relatives were acted upon appropriately by staff. A complaints process was provided but people had not had to use this as issues and concerns were addressed effectively before they became a complaint as such. However, we saw that where minor concerns had been recorded that it was not clear if the actions taken had been effective or if the potential for recurrence had been minimised. One person said, "Over the time I have lived here, I have had to make the occasional complaint and I know how to. There are residents' meetings every four to six weeks, when people can express their views." We saw from these meetings that requests for new and more appropriate flooring had been acted upon. One member of care staff told us, "If someone is not happy with something I can tell generally by their body language as well as when people tell us when things aren't quite right. They can tell us by not eating, being sad, or being very quiet. It is always possible to work out what a person is 'telling' you or communicating by their preferred method."

Good

Is the service well-led?

Our findings

A registered manager was in post and they explained to us, with passion, how they determined the required care needs for each person. All the people and staff we spoke with were impressed by and complimentary about the registered manager. Staff demonstrated the provider's values of treating people as a person and not a set of care needs.

The registered manager had recently been nominated for an award with the National Learning Disability and Autism Awards for the category of learning disability nurse award. This was due to their life-long learning and recently completing a level five quality credits framework qualification.

As a result of the registered manager's commitment to improving people's lives to bring about lasting change people had experienced a high standard of health care. On each occasion this had had a positive impact on the person which had greatly improved the person's quality of life. Examples of this were where people's health conditions were managed much better and people had achieved a weight where they could now do day to day activities such as buying their own clothes and having much less of their prescribed medicines. Another person was now able to sleep in a bed due to their improved health.

One person said, "There isn't a day goes by that I don't see the [registered] manager. They always pop in and see how I am." One nurse staff told us, "My background in management and the [registered] manager's knowledge helps both of us come up with the best way to resolve any [clinical] or management issues. They [registered manager] are very skilled and have a vast knowledge. There isn't much she doesn't know." This helped staff to support people in a positive way such as people achieved something for the first time.

The registered manager was very passionate about the quality of people's lives and the care they received. For example, by attending the provider's best practice meetings for subjects such as caring for people with a learning disability and how best to support each person. Another example we saw was a consistent approach, by the provider, in medicines administration across all of their services and up to date information for people living with dementia. The registered manager and some staff had gained a City and Guilds qualification on this subject. This training had been undertaken as a result of those people's needs who were now using the service. The registered manager told us, "I just want everyone to be happy and have a good life." We saw that they had, as a result of the meetings they attended, provided staff with relevant guidance and shared relevant information with staff according to their role.

To support an open, fair and transparent culture the registered manager spent time at the service outside of normal working hours, such as at night or weekend. This was to help support staff but also ensure that the right standards of care and health care were being provided. One care staff member told us, "The variety of people's care needs here [the service] means [registered manager] can support me as they have a vast knowledge and experience of the people's health conditions that we care for."

Staff told us that their performance could be assessed at any time as the registered manager could call in unannounced which we found that they did. One nursing staff told us, "I get my supervision for my nursing

registration as well as day today support. I haven't been here for long but compared with when I started I am so much more confident. I have their mobile number and I can call them [registered manager] at any time which I do and they always respond in a positive." This was confirmed to us by the registered manager.

Although the number of community links that visited the service was limited people were supported to access these if required. For example, if any person wished to practice their faith or see a religious leader, then this was supported.

Staff who had the responsibility for certain aspects of people's care such as keeping families up to date did this as often as the person wanted. Where people did not wish to share their details this was always respected. Where appropriate, relatives were kept informed about any incidents such as a fall or healthcare appointments and any resulting changes to the person's care.

Quality assurance checks were completed by representatives of the provider as well as the registered manager and lead nurses. This was to identify what the service was doing well and where any potential improvements could be made. For example, audits of people's prescribed medicines and how staff needed to make sure they accurately recorded each administration. We found that they were. Audits undertaken by the representatives of the provider had in May 2016 identified the need for more and more varied social stimulation. This showed us that audits were effective.

Staff told us that they were aware of whistle-blowing procedures and would have no hesitation in reporting their concerns, if ever they identified or suspected poor care standards. One care staff told us, "If I ever became aware or witnessed any such poor care I would take it right to the top of the [provider's] organisation until it was resolved. People living here are vulnerable and rely on us totally. We have to do the right thing." They added that if they ever had to report any concerns that they would be supported without any fear of recrimination.

Staff and management meetings gave staff the opportunity to comment on any areas they felt would benefit people. For example, therapies to prevent escalations in people's behaviours which could challenge others had been introduced as good practice. One staff member told us, "My training in [positive behaviour therapy] means that we always use the least level of restraint. For example, we have people where if you give them a few minutes and then go back there is no need to create any anxieties. Medicines are a last resort and this used rarely."

Staff were also supported by the registered manager with guidance and information from the British Institute of Learning Disabilities and the Social Care Institute for Excellence. This was to help those people who lived at the service with complex health conditions. We saw that in some cases and where possible people's health and reduction in the use of medicines had had a positive impact on the person.

From records viewed we found the registered manager had notified the Care Quality Commission (CQC) of incidents and events they are required to tell us about. We saw that the registered manager had from the provider's meetings shared CQC guidance on when to report medicines errors to the local authority, especially if there had been an adverse impact on the person.

Meetings with the provider and its representatives were held every month as well as staff meetings. The registered manager told us that the operations' manager called them regularly to make sure they had the resources they needed. The registered manager told us that if they ever had a need for additional funding for improvements to the service that these requests were fulfilled.

At the provider's monthly managers' meetings information was shared regarding good and best practice. As part of these meetings staff were regularly reminded by the registered manager of their roles and responsibilities and how to escalate any issues or concerns. This was through formal supervision, staff meetings or at shift hand overs. We saw that communication handbooks were also used to inform staff about changes to people's care such as new medicines.