Valeo Limited

Trabel

Inspection report

26-28 Cambridge Road
Huddersfield
West Yorkshire
HD1 5BU

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11 September 2017
13 September 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Trabel took place on 11 and 13 September 2017. The inspection was unannounced on the first day and announced on the second day. We previously inspected the service on 9 August 2016 and at that time we found the provider was not meeting the regulations relating to managing medicines. On this inspection we checked and found improvements had been made.

Trabel is a care home for twelve people with learning disabilities and behaviour that may challenge others. The home is arranged over three floors and includes two independently staffed flats with one bedroom and two bedrooms. One person is supported in a self-contained bungalow in the grounds. The home is located just outside Huddersfield Town centre.

There was a registered manager in post who had been registered since October 2010. 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 a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Safe recruitment and selection processes were in place and medicines were managed in a safe way for people.

There were enough staff to provide a good level of interaction. Staff had received an induction, supervision, appraisal and role specific training. This ensured they had the knowledge and skills to support the people who lived there.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice, although some best interest processes had not been evidenced. We recommend the registered provider consult best practice in this area to ensure mental capacity assessments and best interest processes are always recorded when decisions need to be made on behalf of people who may lack capacity.

People were supported to eat a balanced diet and meals were planned around their tastes and preferences.

Positive relationships between staff and people who lived at Trabel were evident. Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs.

People were involved in arranging their support and staff facilitated this on a daily basis. People were

supported to be as independent as possible throughout their daily lives.

Care records contained detailed information on how to support people and included measures to protect them from social isolation. People engaged in social activities which were person centred.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

People told us the service was well led. The registered manager and deputy manager were visible in the service and knew people's needs.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of the people were met and that the service provided was to a high standard.

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 in a safe way for people.

Staff had a good understanding of safeguarding people from abuse.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

There were enough staff on duty to meet people's individual needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent to care and treatment was always sought, however some best interest processes had not been recorded.

Staff had received specialist training to enable them to provide support to the people who lived at Trabel.

People were supported to eat and drink enough and maintain a balanced diet and healthy eating was promoted.

People had access to external health professionals.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy, dignity and diverse needs.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and individualised.

People were supported to participate in activities both inside and outside of the service.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Good

The service was well led.

The culture was positive, person centred, open and inclusive.

The management team were visible within the service.

The registered provider had an effective system in place to assess and monitor the quality of service provided.

Trabel

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 11 and 13 September 2017 and was unannounced on the first day and announced on the second day. The membership of the inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in learning disabilities.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioning teams. The registered provider had 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 used a number of different methods to help us understand the experiences of people who used the service. Some people communicated non-verbally and as we were not familiar with everyone's way of communicating we used observation as a means of understanding their experience. We spent time in the lounge area and dining room observing the care and support people received. We looked in the bedrooms of five people who used the service. We spoke with five people and three relatives on the telephone. We spoke with the registered manager, the deputy manager, two senior support workers and two support workers. We looked at four care records, three staff files, accident and incident records, medicines administration systems, maintenance records and quality monitoring systems.

Good

Is the service safe?

Our findings

People told us they felt safe and supported at Trabel. One person said, "I feel safe here. I've got my own space and them down stairs have theirs so we don't have to be together." Another person said, "Staff do my drugs in the morning and then at night. They help me during the night as well." A further person said, "Yes I like it here."

Relatives told us they felt their relation was safe at Trabel. One relative said, "From what I've heard and seen I'm truly satisfied. I see (relation) as quite content and enjoying (relation's) own place." Another relative said, "I know (relation) is safe. I've got no complaints from here. They are doing my job and I don't see any problems." A further relative said, "I know (relation) well. I'd see it in (relation's) eyes if they were unhappy. (Relation's) behaviour and everything has changed."

At our last inspection we found the registered provider was not meeting the regulations related to medicines because some of the systems in place to ensure people received them safely were not always effective. At this inspection we checked and found improvements had been made.

Blister packs were used for most medicines at the home. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. We saw a stock check was completed twice daily and signed by two members of staff. Senior staff completed weekly audits and the registered manager or deputy manager also completed a monthly audit. This demonstrated the home had good medicines governance.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. We saw medicines were administered in the person's room to promote privacy. Staff used personal protective equipment (PPE) and told the person what the medicine was before they supported them to take it.

People's medicines, including topical creams were stored safely in a locked cupboard in each person's room or flat. Body maps were in place to guide staff where to administer topical creams in the medicines records we sampled. One topical cream was stored in the refrigerator in the kitchen, as it needed to be stored below 15 degrees centigrade. The kitchen was never accessed by people without a staff member present and was locked when not in use. We saw the temperature was recorded daily and was below the required temperature for storing the medicine.

Medicines care plans contained detailed information about medicines and how the person liked to take them, including an individual 'when required' (PRN) medicines protocol. Having a 'when required' protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

The registered manager told us all staff at the home completed training in safe administration of medicines

every year and we saw certificates to confirm this. We saw staff competence in giving medicines was also assessed regularly. This meant people received their medicines from staff who had the appropriate knowledge and skills.

All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and CQC had been notified. This showed the registered manager was aware of their responsibility in relation to safeguarding the people they cared for.

Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. We saw information around the building about reporting abuse and whistleblowing.

Systems were in place to manage and reduce risks to people. In people's care records we saw comprehensive risk assessments to mitigate risks in relation to accessing the kitchen, behaviour that may challenge, self-harm, falls, physical health, financial capability, decision making and transport. Risk assessments were detailed and contained clear directions for staff to ensure risk was managed well. We saw these assessments were reviewed regularly and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. This showed the service had a risk management system in place which ensured risks were managed without impinging on people's rights and freedoms.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded in detail and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety in the home.

People and staff told us there were enough staff on duty. The registered manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We saw appropriate staffing levels on the days of our inspection which meant people's needs were met promptly and people received sufficient support.

The provider had their own bank of staff to cover for absence and asked familiar staff to do extra shifts in the event of sickness, as well as using occasional agency staff. This meant people were normally supported and cared for by staff who knew them well.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the registered manager ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). A series of risk assessments were in place relating to health and safety.

People had a personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person

should be supported if the building needs to be evacuated. Regular fire drills were completed and people and staff were aware of the procedure to follow. This showed us the home had plans in place in the event of an emergency situation.

The service was generally clean and odour free. The service employed a cleaner for communal areas and night staff also completed cleaning tasks. People were supported to clean their own flats or rooms and there was a good supply of personal protective equipment to prevent the spread of infections.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they felt confident staff had the skills and knowledge required to support their relation. One community professional said, "The experienced team at Trabel House respond effectively to the complex needs of people living in the property."

We saw evidence in staff files new staff completed an induction programme when they commenced employment at the service. Staff told us they completed e-learning and face to face training and then shadowed a more experienced staff member for up to a month. The shadowing focused on getting to know people's individual needs and preferences. We saw new staff also completed the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. Induction also included observations of staff practice. This demonstrated new employees were supported in their role.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We looked at the training records for four staff members and saw they had completed training in areas such as, infection prevention and control, first aid, food hygiene, autism awareness, MCA and DoLS and safeguarding adults. Staff told us and we saw from records they also completed three days of face to face training in preventing and managing behaviour that challenges and this was updated annually. Staff told us they were supported to update their training and complete nationally recognised level two and three qualifications in health and social care. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

The training matrix showed which staff had undertaken training and highlighted training that was due to be refreshed. Some information on the training matrix was not up to date; however we saw certificates in staff files to confirm the relevant training had been completed.

Staff we spoke with told us they felt appropriately supported by managers and they had supervision every three months, an annual appraisal and regular staff meetings. One staff member said, "The training and support is good. I am really happy here. All the staff have made me feel welcome." We saw not all supervision was delivered in line with the registered provider's policy of two monthly, however we saw supervision was completed regularly and new staff received additional supervision during their induction. Staff supervision covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. This showed staff were receiving regular management supervision to monitor their performance and development needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw 10 people were subject to DoLS authorisations with no conditions attached and two people had been assessed as having the mental capacity to decide to live at the home.

Staff at the service had completed training and had an understanding of the MCA. One staff member told us about one person, who had been assessed as having mental capacity to choose to go out alone, and was at risk of falling. They said staff could explain the risks and offer to go with them, but if they refused they could not stop the person, as they understood the risk and could make their own decision.

It was clear from observations people's autonomy, choices and human rights were promoted. We saw in the care records we sampled mental capacity assessments had been completed for people in relation to the decision to live at the home, the administration of medicines and the decision to accept personal care. Where people may not have capacity to make these decisions, we did not always see evidence best interest processes had been followed. For example one person's mental capacity assessment stated they lacked capacity to consent to the administration of their medicines by staff however there was no record of their representative being consulted in their best interests.

One person who used a door sensor to alert staff when they left the room was considered to understand the reasons for this and had signed a consent form. For the other person who may lack capacity to consent to the use of a door sensor, no mental capacity assessment or best interest discussion was recorded, although records showed the door sensor had been discussed with a community professional involved with them.

The person also had a bed sensor as recommended by a health professional due to their health condition. Good practice was evidenced in a risk management plan and health condition care plan being in place, which also evidenced the person had been involved in the installation of the bed sensor and familiarised with its use; However the registered manager had not recorded a mental capacity assessment and best interest discussion to show the decision was the least restrictive option and in their best interests. This meant consent to the decision was not evidenced to ensure the persons rights were protected.

The registered manager told us these restrictions had been discussed with the person's representative and they would complete mental capacity assessments and best interest discussions with the person and their representative. We recommend the registered provider consults best practice in this area to ensure mental capacity assessments and best interest processes are always recorded when decisions need to be made on behalf of people who may lack capacity.

Care plans and incident records showed physical intervention was only used as a last resort where harm may come to the person concerned or to those close by. All incidents were clearly documented. The incident records showed the event was subject to senior staff review with any lessons learned translated into care plans. Staff we spoke with were able to describe de-escalation techniques and how they minimised the use of restraint.

People at Trabel were supported to have sufficient to eat and drink and to maintain a balanced diet. One person said, "I help staff make my food in the kitchen, and I do my washing and drying two days a week. Staff talk to me about eating healthy food and I like to do that too." One person who communicated non-

verbally was very enthusiastic about meal times and used sign language to tell us they enjoyed their meals.

Staff in the main house told us they did the cooking and people who used the service joined in with the household shopping. People using the two individual flats and the bungalow shopped for and cooked their own food, with staff support, and ate in their own dining areas.

Meals were planned around the tastes and preferences of people who used the service. Each person had a list of food likes and dislikes in their care records, which was used to inform meal planning. Some people used adapted cups to support them to drink independently. We saw the individual dietary requirements of people were catered for.

Meals were recorded in people's daily records. This included a record of all food consumed, including where food intake was declined and details of the food eaten, although there were some gaps in recording. By the second day of our inspection the registered manager had checked food records and spoken to seniors to ensure they checked these regularly. People were weighed monthly to keep an overview of any changes in their weight. This showed the service ensured people's nutritional needs were monitored and action taken if required.

Kitchen refrigerator temperatures were slightly higher than recommended on two days in the week prior to our inspection and the action taken to reduce these had not always proved effective. The registered manager told us they would discuss this with the maintenance team and request a new refrigerator to ensure temperatures remained within recommended limits.

One person said, "I went to the hospital with (staff) last week to see the nurse and she said I'm doing really well; I like staff to take me." People had access to external health professionals as the need arose. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy and psychologists. People also had an up to date health action plan in their care records. This showed people received additional support when required for meeting their care and treatment needs.

The atmosphere of the home was comfortable and homely. There were pictures and photographs in the communal areas, including art work created by a person who lived at Trabel. Specialist weighted furniture was used to reduce the likelihood of it being used as a missile. One of the settees in the lounge had been damaged and the registered manager told us this would be replaced. Maintenance tasks had been completed as required, including new flooring in a person's room to support their specific needs. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service. Some areas were in need of updating, for example, the kitchen sink was stained. The registered manager told us the kitchen was being replaced in the near future.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "Staff are really helpful to me." Another person said, "Yes staff are nice."

One relative said, "(Staff member) has helped (relation) deal with things and helped other staff to understand about (relation) and how to get the best from them." Another relative said, "The staff seem really caring. You can see they care."

One person told us they did not like living at the home and we saw from records this had been explored with the person over many years. They also told us at times they liked the staff. We saw the staff member supporting the person was very supportive and kind, listened carefully to their concerns, offered solutions where possible, recorded these and passed them on to senior staff.

One community professional said, "I have found the group of staff working closely with (name) to be caring, responsive and keen to analyse and consider the best ways to respond to (name's) needs that can at times be challenging."

Positive caring relationships were developed through staff understanding people's needs and their personalities. It was clear from our discussion with staff they knew all about the people they supported and enjoyed supporting them. One staff member said, "I enjoy the service users. I enjoy helping people." Another staff member said, "I love it."

Staff spoke with people respectfully and in tones of voice which suggested equality and fairness. People told us they had been consulted about the care provided for them and we saw staff asked permission before delivering care.

Staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter. Staff told us they kept people covered during personal care and ensured doors were closed. Some people had their own room key. We saw staff were thoughtful in small ways, for example by helping one person to tuck their jeans pocket back in to promote their dignity and self-esteem. People wore clothes and accessories in keeping with their personal style and preferences.

People were supported to make choices and decisions about their daily lives. One staff member said, "I show (person) the boxes of cereal. (Person) won't put clothes on if they haven't chosen them. (Another person) has some picture cards." Another staff member said, "(Person) chooses to go to bed about 9pm with a glass of wine." Staff used speech, gestures, sign language, photographs and facial expressions to support people to make choices according to their communication needs. Information was presented in easy read formats to promote good communication and care plans contained details of how to recognise when a person was unhappy or happy using non-verbal cues. One person had a new easy to read clock to support them to structure their time and manage their own week and family visits.

People's individual rooms were personalised to their taste, for example one person had lots of soft toys they enjoyed collecting and a further person had posters on the walls of their favourite singers. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. One person said, "I have vacuumed this morning and enjoy having it clean. I have my own music and television; I go out to do my shopping and everything." Another person said, "I do the house shopping. At the weekend I like to bake a cake."

One relative said, "They help (relation) with (their) independence and this has helped (relation) move on."

One member of staff said, "I try to make people do as much as they can for themselves. If they can do their own bedroom or their own laundry or encourage them to brush their own teeth." We saw from records people took part in the house food shopping, or cleaning their own flats and helped to prepare vegetables for Sunday dinner. This showed people were encouraged to maintain their independence.

People's diverse needs were catered for and equality was promoted within the service. One person was supported to make cards to celebrate their religious festivals and to take part in festivals with their family, as well as enjoying their cultural heritage.

Staff told us they would respect people's diverse needs by ensuring they understood the person through their care plan, talking with them and their families and supporting their cultural choices. We saw from care plans people were supported with their gender and sexuality choices. Each of the care records noted if people had a preference for the gender of the care worker who supported them. This demonstrated the service respected people's individual preferences.

Staff were aware of how to access advocacy services for people if the need arose and some people had an independent mental capacity advocate (IMCA). An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their representatives had been consulted regarding end of life plans and wishes, where appropriate, and these were recorded if they wished.

Good

Is the service responsive?

Our findings

People told us they were supported to make decisions about their daily life and were consulted on every aspect of their support. One person said, "I don't have a plan, I do my own thing. I had plans at the other place. I don't need one here. I have a lot of space here and I do my own thing. I go to bed when I like and get up when I want." Another person said, "Staff listen to you and I listen to them when they tell me things. They help me with good ways."

One relative said, "(Staff member) knows (relation) inside out and has been with our family for a long time. (Relation) has come on so much since being at this home. I can see it in (relation's) eyes that they are happy. If there was ever a real problem (relative) would ring me or the staff would."

The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. We found care plans were person centred and explained how people liked to be supported. Entries in the care plans we looked at included, "How to support me." And "What's important to me." For example; "Clothes and looking good. Family and friends." And, "I like talking to people my own age." One person who enjoyed writing had written part of their own care plan. This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

We looked at four people's care plans. Care plans were person centred and contained detailed information covering areas such as evening routine, mobility, hygiene, communication, continence, medication, decision making, money, relationships and sleep and included long term goals the person was working toward.

Care plans also contained detailed information about people's individual behaviour management plans, including details of how staff would care for people when they exhibited behaviours that challenged, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People's needs were reviewed as soon as their situation changed. The manager told us, and we saw from records, reviews were held regularly and care plans were reviewed and updated monthly or when needs changed. These reviews helped monitor whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage.

Daily records were also kept detailing what activities the person had undertaken, what food had been eaten, their mood and any incidents.

We saw staff at Trabel were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people, and listened to their responses. This meant that the choices of people who used the service were respected.

One person said, "I'm going to the hairdressers on Thursday for my (colour) hair doing, they wash it and dry it too. I go to (name of day service) every Wednesday and we play Bingo and dance. I like people there. I go to the stretch and flex, every two weeks. I go to ten pin bowling, and go to the pub for my tea and have a drink."

Staff spoke with good insight into people's personal interests and we saw from people's support plans they were given opportunities to pursue hobbies and activities of their choice. For example one staff member said, "(Person) likes to go bowling and play pool." On the day of our inspection one person was going on holiday, two people were being supported to visit family members; one person was going to an appointment and lunch. One person was using table top items in the lounge. A further person was listening to music in their room in line with their recorded preferences. One person who used the service told us they liked to bake cakes and this was part of their activity time table. We saw each person had an individually planned holiday. One person said, "I'm going to Whitby with my staff in November for a week holiday, and Blackpool to see the lights."

Staff told us and we saw from records how they enabled people to see their families as often as desired. One member of staff said, "We take (person) to see their family every week." This meant staff supported people with their social needs.

One person said if they were not happy with things, "Then I speak to staff and they sort things out for me. They have put the heating on when I'm cold and they open windows when I want some fresh air. They also help me calm down when I'm feeling angry."

One relative said, "I've never had a complaint about this place unlike others (relation) has been at." Another relative said, "Trust me if there was any problems you'd hear about it from me. I'm straight talking." The relatives we spoke with told us staff were always approachable and they were able to raise any concerns. We saw there was an easy read complaints procedure in people's care files. Staff we spoke with said if a person wished to make a complaint they would facilitate this. The registered manager showed us there had been no formal complaints since our last inspection. The registered manager was clear about their responsibilities to respond to and investigate any concerns received. Compliments were also recorded and available for staff to read.

Good

Is the service well-led?

Our findings

People told us the service was well led. One person said, "I don't think I'm unhappy here I think I like living here a lot." Another person said, "Yes the manager is (name of manager). You were just talking to her. She is nice and I see her a lot. She helps me with things." A further person said, "I like (name of area manager)."

A relative said, "I like (name of registered manager); I have no complaint about any of the staff. If there are any problems they ring me."

One community professional said, "I have worked closely with (name of deputy manager) and I have been impressed with their leadership of a diverse and large group of staff, some with years of experience, and others new to care of people with learning difficulties and complex needs."

There was a registered manager in post who had been registered since October 2010. The registered manager was now at the service full time since July 2017, having previously managed two services. A deputy manager was in post and each shift was led by a senior support worker.

Staff told us they felt supported by the management team who always acted on their concerns. One staff member said, "I can go to them with anything." Another staff member said, "This is the best home I have worked in. There is good morale; good communication and I feel supported." A further staff member said, "Yes it's well led. There doesn't seem to be any problems. Everything runs smoothly."

The registered manager and deputy manager had an in-depth knowledge of the needs and preferences of the people they supported. They told us they felt supported by the provider, and were able to contact a senior manager at any time for support.

The registered manager said their aim was to, "Move the service forward, achieve the best for the service users and help them achieve what they want to in life." The registered manager told us they attended monthly managers' meetings, training and events to keep up to date with good practice. This meant they were open to new ideas and keen to learn from others to improve the service.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. House meetings were held regularly and topics discussed included fire safety, holidays, food choices, happiness, health and activities. We saw activities requested at meetings had since been organised, including visiting the cinema and having a buffet meal, and a requested visit to Blackpool illuminations had been planned. Photographs of meals and holidays were used at meetings to support people's choices.

People who used the service and their families were also consulted about the service on an individual basis. People had been supported to fill in service user questionnaires about the quality of the service and these had been compiled by the provider to look for themes. Questionnaires were sent out to family members every year, the latest being in August 2017 and none had yet been returned.

Staff meetings were held every few months. Topics discussed included staff training, completing kitchen checks, individual resident's needs, safeguarding, incident records and infection prevention and control. Action from the last meeting was discussed and goals were set from the meeting. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people living at the home.

We saw audits were maintained in relation to premises and equipment. There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Care plans and documents were also reviewed and audited regularly. The registered provider had recently introduced policy knowledge checks with staff in areas such as medicines, confidentiality and safeguarding policy to ensure staff knowledge was up to date. This showed staff compliance with the registered provider's procedures was monitored.

Information was passed to the registered provider in a monthly report in areas including incidents and accidents, safeguarding, training compliance and staff supervision. The locality manager visited the home regularly to provide support and the provider's compliance team also visited to complete audits and ensure compliance with the provider's policies and procedures. The registered manager worked to an action plan completed in conjunction with the locality manager and we saw action had been completed within the timescales set. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation.

The registered manager understood their responsibilities with respect to the submission of statutory notifications to the Care Quality Commission (CQC). Notifications for all incidents which required submission to CQC had been made.