Longley Hall Limited

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Inspection report

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Tel: 01142423773

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection was carried out on 30 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be attending. One Adult Social Care (ASC) inspector carried out the inspection. The service was last inspected on 23 April 2013 and was found to be meeting all the regulations we reviewed.

Longley Hall Limited provides supported accommodation for people with learning disabilities and people on the autistic spectrum or people with a dual-diagnosis aged 18-65 years. It includes one self-contained flat and four flats with shared space and provides 24 hour support. At the time of the inspection the service supported 16 people. The property has accessible gardens with seating and is in close proximity to Longley park and public transport

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had a new quality assurance system in place, but this required further embedding so that audits were able to identify potential areas for improvement.

The registered manager was able to demonstrate they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the Court of Protection. However, we found that Mental Capacity Act (2005) guidelines were difficult for the registered provider to follow, as local authority court of protection orders were not always forthcoming.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the service deemed essential, such as safeguarding, medication and MCA. However, only three staff had completed training in 'challenging behaviour' and 'conflict management'. We made a recommendation about this is in the report.

We found that staff had a good knowledge of how to keep people safe from harm and we found that the recording and administration of medicines was being managed appropriately in the service. Staff had been employed following appropriate recruitment and selection processes.

Assessments of risk had been completed for each person and plans had been put in place to minimise risk. The service was clean, tidy and free from odour and effective cleaning schedules were in place.

People's nutritional needs were met. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day. People told us they were well cared for and we

found people were supported to maintain good health and had access to services from healthcare professionals.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported.

People were offered a variety of different activities to be involved in. People were also supported to go out of the home to access facilities in the local community.

The registered provider had a complaints policy and procedure in place and there were systems in place to seek feedback from people and their relatives about the service provided.

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 displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

The home had an effective system in place for ordering, administering and disposing of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the court of protection and followed the guidelines of the Mental Capacity Act 2005.

Staff received an induction and training in key topics that enabled them to carry out their role. However, only three staff had completed training in behaviour management.

People's health needs were met. People who used the service had access to additional treatment from healthcare professionals, when needed.

People had access to adequate food and drink and information was available to meet any specific dietary needs.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable

about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. However, these plans did not always contain enough detail for some aspects of people's care.

People had access to a range of activities and were able to access the local community.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was in the process of implementing a new quality assurance system. However, further review and implementation of this system was needed.

Some of the records viewed during the inspection were up-to-date.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

Longley Hall Limited

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 registered 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 30 September 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

As this was a planned inspection the registered provider would have been asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, on the day of our visit the registered manager informed us they had not been asked to submit a PIR, only contact details for people that used the service, their relatives and staff.

During the inspection we spoke with two members of staff, a team leader, the registered manager, two people who used the service and three people's relatives. We spent time observing the interaction between people who used the service, the staff and visitors.

We looked at all areas of the service, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, people's medication records, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

People living at Longley Hall told us they felt safe and said the staff were there to help them if needed. The three relatives we spoke with told us that they had no concerns regarding people's safety at the service. One commented, "Yes, [Name] is safe. They have recently bought a new walking frame. They are much more stable than on the last one, it went a bit too fast for [Name]." Another said, "I know where [Name] is and they are happy."

The registered provider had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authority's safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local authority's safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report accidents, incidents and concerns.

We saw that all of the staff had completed training in safeguarding vulnerable adults from abuse and the staff we spoke with told us how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to the senior member of staff on shift or the registered manager. They also told us they knew how to escalate the concerns if they felt the issue had not been appropriately addressed. Staff told us, "I would speak with the team leader or the manager. If nothing happened I could contact you [CQC]."

We saw that accidents and incidents were recorded and behaviour observation charts were put in place when people displayed distressed or anxious behaviours. However, we found that these were stored in people's individual files. This made it difficult to accurately audit how many incidents had occurred each month and to determine if any areas required improvement.

We discussed staffing levels with the registered manager. They explained they currently had their full allocation of staff, although two staff were currently not at work. We saw that most people had allocated one-to-one hours and this ranged from six hours per week to 105 hours per week depending on the individual's level of need. We reviewed the staff rotas and saw that when people had one-to-one hours allocated this was clearly recorded and the number of shared hours were also identified. This ensured that there were sufficient numbers of staff to meet people's needs.

We saw care plans contained risk assessments that were individual to each person's specific needs. Risk assessments identified initial levels of risk and then reassessed the risk following the implementation of the appropriate control measures. For example, we saw that one person was at risk of choking whilst eating and drinking. This meant that staff had to supervise all mealtimes and offer encouragement to chew food fully, before swallowing. This showed that plans were in place to minimise risks to people living at the service.

We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who

cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to. We did note that some of the PEEP's had not been signed by the person completing the form and this required addressing.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, fire extinguishers, emergency lighting and gas safety. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises. However, we did note that some areas of the premises required attention. For example, we saw that new flooring had recently been laid in one of the flats and this meant that some of the fire doors were sticking. We discussed this with the registered manager and they arranged for this to be remedied to ensure the service remained safe.

We looked at the recruitment records for three staff members. We found that application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them. We looked at one of the applicants interview forms and saw that questions related to possible scenarios that the member of staff could encounter, including how they would respond if they witnessed abuse. This enabled the registered manager to gauge whether they had the right attributes to join the staff team.

We looked at how medicines were managed within the service and checked three people's medication administration records (MARs). We saw that medicines were obtained in a timely way so that people did not run out of them, were stored securely, administered on time, recorded correctly and disposed of appropriately. People had regular medication reviews, and we saw that medication was adjusted accordingly. Some people who lived at Longley Hall had been prescribed controlled drugs (CDs); these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was a suitable storage cabinet and staff were recording the administration of these medicines in a CD record book. We checked a sample of CDs held against the records in the CD book and found that these balanced.

Weekly and monthly medication audits were completed and this included stock checks and checks of people's MARs. When errors were identified, we saw that action was taken to address this with staff to minimise reoccurring errors. For example, gaps had been identified on one person's MAR chart. The member of staff responsible had been identified and supervision had taken place to address the concerns, and a clear explanation of the action that would be taken should errors continue to be identified was provided.

During the inspection we found that the service was clean, tidy and free from odour. Cleaning schedules were in place in each area of the service and these provided clear guidelines for staff to ensure they knew which tasks required completing each day / night. This showed us that the registered manager had considered the impact of infection for people that used the service and had put interventions in place to minimise this risk.

Requires Improvement

Is the service effective?

Our findings

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. For people living in their own home or supported living this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA and found that some of the people using the service were under significant levels of supervision to ensure their safety and enable them to access the local community. For example, we saw that two people living at the service had one-to-one supervision for up to 15 hours per day. However, we found that no applications to the Court of Protection had been submitted. We discussed this with the registered manager who told us that this issue had been identified and that they were working closely with the Local Authority to ensure that applications were made as necessary.

We viewed peoples' care files and found that capacity assessments and best interest meetings had not always taken place prior to decisions being made about people's care. However, after the inspection the registered provider sent us copies of some capacity assessments that had been completed by the local authority, which were appropriate for evidencing people had been assessed regarding their mental capacity. Best interest meetings are held when people do not have capacity to make important decisions about their care needs. Health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. However, where a meeting cannot be convened the very least that should happen is for a consultation to take place with those involved in a person's care so that a best interests decision can still be made. The registered provider assured us that consultations or meetings had taken place where they were required.

We saw a number of service user agreement / consent forms for decisions in relation to finances, access to care plans, photography, and tenancy agreements had either not been signed, or had been signed by the person's key worker. We noted there was no evidence that capacity assessments had taken place prior to these decisions being made, nor any evidence that people's representatives had been consulted. However, after the inspection the registered provider sent us copies of some capacity assessments in relation to four people's ability to understand about their finances and tenancy agreements. These showed that capacity was assessed for specific decisions to be made and stated when a best interests' decision was needed. The recorded evidence to show how these best interest decisions were made was not forthcoming. This has been addressed later in the report in respect of record keeping. In one person's file we saw that, although they were deemed to have capacity for some decisions, they were not deemed to have capacity to engage in relationships with people of the opposite sex. Again, there was no recorded evidence that this decision had been made as a best interest decision.

During our discussions with staff, we found they had the appropriate levels of knowledge regarding MCA for their roles. Staff explained how they requested consent before carrying out any care tasks by asking people and talking them through each step of the care intervention. They used some basic communication skill such as thumbs up and thumbs down to assess whether people were happy to be supported. Staff were also able to recognise slight differences in people's behaviour to determine whether they were in a positive or negative mood. One member of staff said, "[Name] will rock back and forwards, but they have several different types of rock and you slowly start to understand what each one means." This showed staff were able to understand when people were happy to be supported with care tasks. The registered manager told us that restraint was not used at the service and this was confirmed by the staff we spoke with.

New staff were required to complete an organisational induction that included information on the aims and objectives of the service and the day-to-day running of the service. We also saw that staff were required to complete training modules in topics such as safeguarding, health and safety, fire safety and personal care. Staff told us they were required to shadow more experienced members of staff prior to working alone. On the day of the inspection we saw that one new member of staff was shadowing a more experienced member of staff as part of their induction.

The registered manager explained that training was delivered through distance learning packages and face-to-face training. The training matrix record showed staff had completed training in a range of subjects that were deemed essential for their role. These included health and safety, safeguarding, food safety, medication and MCA training. We also saw that staff had completed training in more specialist subjects including epilepsy and autism awareness. However, despite seeing records of incidents where staff had been verbally and physically assaulted by one of the people who lived at the service, we saw that only three members of staff had completed training in relation to behaviour that could challenge the service and conflict management. We also found that although two people using the service could communicate using Makaton, there were no staff currently trained in this form of sign language.

We recommend that the registered provider seeks advice and guidance on accessing appropriate training for staff that ensures they meet the individual needs of people who live at Longley Hall.

People who used the service were involved in decisions around the weekly menus, the purchasing of ingredients from the shops and where possible the preparation of meals. Some people prepared their own meals with differing levels of support from staff. One person who used the service told us, "I have learnt how to make lasagne; I shared it with [Name of other service user]." We saw people had access to their own drinks and snacks throughout the day. One person said, "I share a fridge with [Name of other person]. I don't mind this; we both know what is ours. I can keep snacks and drinks in my room, so I can have them whenever I want." One relative told us, "I visit on a Sunday and the meals always look really good. There are always clean plates at the end so they must enjoy it." Another said, "[Name] goes out shopping with the staff, [Name] decides what they want then they cook it together. He's put a bit of weight on recently so the staff have given him some advice on making healthy choices and cutting back on some types of food."

People's health needs were supported and were kept under review. We saw evidence that individuals had input from their GP's, opticians, dentist and more specialist professionals including the speech and language therapists (SALT). We noted in the safeguarding file that a concern had been raised following a member of staff not following the SALT guidelines in place for one person who lived at the service. We saw that this had been appropriately addressed by the registered manager once it had been brought to their attention. Where necessary people had also been referred to the relevant healthcare professional to ensure they received the most appropriate care. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken, as required. One person told us, "If I feel unwell then I

speak with the staff or [Name) the manager. They will call the doctor or will get some medication from the chemist." During the inspection, one person complained of stomach pains. As this was identified in the person's care plan as an area of concern, a member of staff contacted the GP and arranged for them to visit.

During this inspection we noted that some of the bedrooms and the kitchens required refurbishment. We discussed this with the registered manager and they informed us that new kitchens had been ordered for all four flats and work on them would take place in order of need. We also saw that a programme of refurbishment had started on people's individual rooms and communal areas and the work so far had been completed to a high standard. Although elements of the environment required updating, people clearly felt this was their home. They were able to decide how they wanted their own bedrooms to be decorated and in the rooms we viewed we saw that people had a variety of possessions that were important to them. People were familiar with their surroundings and were able to safely navigate their environment. We spoke with one person and they told us that they were due to have a new shower and kitchen fitted in their flat. Following the inspection we spoke with their relative and they told us that this work had now started.

Good

Is the service caring?

Our findings

On the day of the inspection the service had a relaxed and friendly atmosphere and we saw that people who used the service were relaxed and happy around staff. We saw that people looked well cared for and were well presented. One relative told us "[Name] is well looked after. The staff are really nice, [Name] has their favourites, but that's normal."

We observed that people went about their daily lives and moved around the service as they wished. People chose when they wanted the company of staff and would seek them out if they wanted to spend time with them, ask a question or show them something. Each flat had large communal areas and people had their own rooms so were able to have time to themselves whenever they wanted to. One person who lived at the service told us, "The staff give me support with lots of different things. They help me with cooking, cleaning and managing my money." Another said, "They help me look after my flat and take me out when I want."

We observed staff interacting with people in a manner appropriate to each person. We found that their approach was professional, but friendly and caring. Staff spoke with people in a polite and respectful way and showed an interest in what people wanted to say to them. For example, one person knocked their hand on the kitchen table and started to become distressed. The staff member supporting them quickly intervened, rubbed their hand and stated, "Lets' have a look at it, it looks fine to me, nothing broken." The person quickly relaxed and started to laugh with the member of staff.

The promotion of people's independence and personal development was an important element of the service provided at Longley Hall. Staff told us that some of the people who used the service were very independent only required prompting to ensure that personal care and domestic tasks were completed. Others were more reliant on staff for various personal and domestic care tasks. One member of staff told us, "We try to encourage people to be as independent as they can be and we see that people develop new skills. We are working with [Name] at the moment to help them eat and drink by themselves and join the others at the dining table."

Staff explained how they ensured people were given choice whenever possible. They told us that when people were unable to verbally communicate they use different techniques to ensure they were understood. For example, pointing at a choice of clothes, using picture cards and using google images to help people choose what food they would like. Staff said they assessed how people responded to different suggestions in relation to activities and how they spent their leisure time. We saw that people were involved in decisions about how their own room and the communal areas should be decorated and they were also consulted on the style and design of the new kitchens that had been ordered.

Relatives told us they were welcome at the service, free to visit as often as they pleased and stay as long as they liked. One said, "The staff are great, they always offer me a cup of tea and make me feel welcome." Another told us, "When I get there I make sure I check that everybody is ok and then I spend some time with [Name].I usually visit around mealtimes, they are happy for us to visit whenever we want." Relatives also said they were in regular contact with their family members by phone. One said, "They call most days and let us

know what they have been up to. It's nice to catch up so I know they are ok."

Staff had completed training in equality and diversity and discussions with the staff revealed there were people living at the service who had different needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that people from all backgrounds were welcome at the service and that steps were taken to ensure that all people were treated with dignity, respect and without discrimination. We saw that people were able to express themselves as they chose and that the staff offered a safe environment for this to happen.

Good

Is the service responsive?

Our findings

Support plans had been developed from information gained during initial and on-going assessments, discussions with people who lived at the service and their relatives, local authority care plans, input from health and social care specialists and from observations made by staff when they were supporting people. Support plans included information regarding all aspects of a person's life and detailed what tasks people could carry out independently and those they required support with. Each support plan was written in a person centred way, included people's likes and dislikes. They identified clear goals for each specific element of the care plan.

People had individual behaviour support plans in place to inform staff how to best support them during periods of heightened anxiety and distress. We saw that these plans identified any triggers, the types of behaviour that could be displayed, how staff should address these behaviours and distraction techniques that were specific to each person. We saw from staff induction notes that they were required to familiarise themselves with individual behaviour plans to ensure they knew how to respond.

We saw that reviews took place and people's relatives confirmed they were invited to attend these. We saw that these discussed 'what is working', 'what is not working' and identified 'how do we change it.' For example, improving family relationships was identified as one person's goal. We saw that a home visit had been planned and a date had been agreed when this would take place. However, we saw that other agreed actions did not identify the person responsible for making sure it took place or a specific timeframe. These are important to ensure that agreed actions are always followed up in good time.

People who used the service were encouraged to engage in activities of their choosing to ensure they were engaged and occupied during the day. In addition to the usual activities associated with daily living including shopping, cooking, collecting money from the bank and domestic tasks, people also enjoyed a variety of social and independent activities. Activities were recorded during tenant discussions and this provided details of family visits and when opportunities were provided for people to access their local communities. We spoke with one person who lived at the service and they told us, "I play football in a team and go to HUBS community centre and play snooker. I sometimes go with [Name of person living at the service]." All of the relatives we spoke with told us that their family members were busy and engaged in activities. Comments included, "[Name] is always out and about and we have to ring ahead when we visit to make sure [Name] is going to be home. [Name] goes shopping, goes to watch the football and attends day centres, [Name] loves it", "They take [Name] out shopping for food and they love to go clothes shopping and for meals out" and, "[Name] is always busy and likes to get out and about. They go out on their bike, and they were at Bingo yesterday."

In addition to activities that took place outside of the service, people had developed their own interests that they could take part in within the service. This included karaoke, arts and crafts, computer games and spending time watching TV or listening to music.

On the day of the inspection, four of the people who lived at the service were away on holiday. Three people

who shared one of the flats were on holiday together in Skegness with the support of staff and one person was away in Spain on a holiday arranged by the day centre they attended. All of the people who lived at the service were provided with the opportunity to go on holiday at least once a year. Some people found this too stressful, however the registered manager and the staff team still tried to encourage them to have time away from the service to explore new environments.

People were able to decide who they wanted to spend their time with and we found that some had developed good relationships with other people they lived with and the staff team. A relative told us, "A new lad has moved in fairly recently and they are really pally. They hang around together and go out together every now and again." However, one person told us that they did not always get along with one person they lived with and that the person sometimes tried to lash out at them. We discussed this with the registered manager who told us, "Compatibility is quite good at the moment, the one-to-one hours really help as staff can keep people occupied and try and reduce any disagreements between tenants and step in when needed."

All of the people we spoke with told us they knew how to make a complaint, but they all said they had not needed to. The register provider had a complaints procedure in place and we saw that all complaints were recorded in a complaints file. We looked at the complaints file and found the last recorded complaint had been received in August 2016. We saw that when complaints had been received they were investigated and 'signed off' by the registered manager. We noted that although the complaints procedure included the details of the Care Quality Commission it did not signpost people to the Local Government Ombudsman (LGO) should they be unhappy with how a complaint was handled. We discussed this with the registered manager who assured us the procedure would be updated to include these details.

We noted that no meetings had taken place for people using the service or their relatives. We discussed this with the registered manager who told us, "We found that tenant meetings were not always productive as people have different abilities in terms of their communication. This meant people who were able to easily communicate their thoughts and feelings dominated the meetings. So, we started to complete individual tenant discussions instead." We viewed the tenant discussion records and saw these enabled people to make choices regarding mealtimes, activities, outings and any other topics they wanted to discuss. We also saw that satisfaction surveys had recently been distributed and the registered manager was waiting for them to be returned before analysing the information.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who was registered with the Care Quality Commission (CQC). Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way.

A quality assurance system was in the process of being implemented by the registered manager and this included audits of medication, infection control, finances and care plans. However, the quality assurance process had not identified that there was a lack of recorded evidence around best interest decisions that had been reached and made and that staff had not completed training in relation to 'challenging behaviour' and conflict management.

The registered provider is recommended to embed and review quality assurance systems so they are more effective at improving the quality of service provision.

People spoke positively of the registered manager. A member of staff told us, "The new manager has worked wonders. The service is much more organised now, staff are working better as a team and everything feels much more positive." Another said, "[Name] is very approachable; you can talk to them about anything" and, "They are really supportive and always have a positive response to any suggestions." One person who lived at the service told us, "[Name] is nice; I sometimes help them in the office."

We saw that the registered manager was knowledgeable about people who lived at the service; they were aware of their individual needs and they knew how to approach them. It was clear that people using the service enjoyed the company of the registered manager. They were quick to approach them, keen to spend time with them and wanted to discuss how they were, what they had been doing and discuss any concerns they may have. People who used the service were free to enter the office and talk with the registered manager and other staff. This meant that people did not feel excluded from areas of the service and they had opportunity to talk in private about anything they wanted.

The records we viewed evidenced that the registered manager was aware of the need for swift action to be taken when staff had acted in an inappropriate manner. The registered manager explained that the safety and well-being of the people living at the service was paramount and that any actions by staff that could negatively affect this would be addressed and disciplinary action would follow when necessary.

Quality assurance systems were currently under development. The registered manager had developed an 'update document' and this addressed CQC's five questions and outlined areas that required improvement. For example, the registered manager had identified that quality assurance surveys had not been completed by all the key stakeholders, including people living at the service, the staff and visiting health and social care professionals. We saw that staff and tenant surveys had recently been distributed and the service was still waiting for these to be returned. We viewed the surveys that had been returned and found that these were mostly positive. However, they had also identified some areas that the registered manager was in the

process of addressing. These included comments in relation to the general upkeep of the premises and the amount of paperwork that staff were required to complete.

The registered provider had clear aims and objectives and these were listed in their statement of purpose. The service aimed 'to offer person centred, flexible, high quality, personal care services designed to meet the needs of the individual, with the objective of ensuring that people are kept safe, are listened to, treated as individuals and supported by a fully trained workforce.'