Rosecroft Care Limited

Rosecroft

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

This unannounced comprehensive inspection took place on 5 March 2018.

Rosecroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service was not registered to provide nursing care. The service provides accommodation for up to five people who have learning disabilities and needed a range of support with their care and health needs.

Accommodation was provided in a detached chalet bungalow in a quiet residential area, close to public transport links and local and shops. Accommodation was arranged over two floors and each person had their own bedroom. The service benefitted from an enclosed back garden and a separate activities building set within the grounds.

At our last inspection on 16 December 2016, the service was rated 'Good' in the Effective, Caring and Responsive domains and 'Requires improvement' in the Safe and Well Led domains. The overall judgement rating for the service was 'Requires Improvement' and we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 17 HSCA RA Regulations 2014 Good Governance and Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed. This was because we found that the provider had not ensured systems or processes to assess, monitor and improve the quality and safety of services were fully effective and the provider had not fully applied established recruitment systems to ensure all processes were embedded into practice.

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

There were now effective staff recruitment and selection processes in place. A member of staff had been employed since our last inspection and the recruitment process had been robust and all the appropriate checks were completed before staff were employed.

We found there was clear and detailed guidance in place for staff to follow for people who had specific health conditions, for example, epilepsy. The guidance included individual symptoms or indicators which may precede a seizure and the support the person would need.

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

This service had a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also responsible

for looking after other services owned by the same provider.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Staffing arrangements were flexible in order to meet people's individual needs. Rotas and our observations noted sufficient numbers of skilled staff were deployed to ensure people's needs were met safely.

Staff received a range of training and regular support to keep their skills up to date in order to support people appropriately. Staff spoke positively about communication between staff at the service.

Staff demonstrated a good understanding of what constituted abuse and how to report if concerns were raised.

Measures to manage risk were as least restrictive as possible to protect people's freedom. Risk management considered people's physical and mental health needs.

Medicines were safely managed on people's behalf as people were not able to manage their own medicines because of their complex needs. There were systems in place to ensure people received their medicines as prescribed.

Staff ensured infection control procedures were in place. People's individual needs were met by the adaptation, design and decoration of the premises. Bedrooms were personalised and people's preferences were respected.

Care files were personalised to reflect people's personal preferences. Care plans were pictorial, individual and depicted people's social, physical, emotional needs. Information was accessible and in format that people could understand.

Risks to people were assessed and appropriate steps were in place to mitigate any identified risk. Similarly incidents and accidents were monitored to ensure staff learnt from them.

Staff understood their responsibility to help protect people from discrimination and ensure people's rights were protected.

People were treated with dignity and respect. Staff were kind, caring and people enjoyed a friendly atmosphere.

People were supported and encouraged to maintain their independence and do as much for themselves as possible.

People were able to engage in activities and had many options available to them. These included art, crafts, music, swimming, walking, and eating out. There was strong support of relationships with friends and family.

People were supported to maintain a balanced diet, which they enjoyed. People's health care needs were met through working with external health care professionals and staff's detailed knowledge of the people

using the service.

There were policies in place that ensured people would be listened to and treated fairly if they complained about the service.

Audits and checks were carried out in-house and through the provider, so any problem could be identified and rectified. The premises were maintained through a programme of maintenance and servicing.

The registered manager showed strong leadership and a passion for the people in their care.

The registered manager was aware of when notifications had to be sent to CQC. This showed they understood their legal responsibilities.

Further information is in the detailed findings below.

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.

Checks were in place so only suitable staff were employed.

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

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

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

People's medicines were administered by trained competent staff.

Is the service effective?

Good

The service was effective.

Pre-assessment processes ensured staff were provided with the information required to meet people's needs effectively.

People were supported by staff who received an induction and training which provided them with the skills for the job.

People were supported to maintain a healthy diet and good health. People's health needs were managed well through regular contact with community health professionals.

People's rights were protected because the service followed the appropriate guidance. Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff treated people with dignity and respect and supported them to make decisions and express their views.

Staff promoted people's equality, diversity and ensured their human rights were upheld.

People were supported to communicate with staff in a variety of ways to ensure their voice was heard.

Is the service responsive?

Good

The service was responsive.

Care files were personalised to reflect people's personal preferences, which were met with staff support.

People were supported to take part in a variety of activities that were of interest to them.

Plans were in place to ensure people maintained relationships with their loved ones.

There was a complaints system in place and people knew how to complain.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about communication between staff at the service.

The service sought people's views through questionnaires and regular contact via phone calls and visits.

The provider's visions and values centred around the people they supported, which ensured their equality, diversity and human rights were respected.

There were a number of audits in place to assess the quality of the service provided.

Rosecroft

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 unannounced inspection took place on 5 March 2018. The inspection was carried out by one adult social care inspector.

Before the inspection, we reviewed the information we held about the service. We asked the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

People's ability to communicate was limited, so we were unable to talk with everyone. People communicated verbally, some with the support of hand signs and symbols. We spoke to two people and four members of staff, which included the registered manager, a team leader and two care staff. We also spent time in communal areas observing the interactions between people and staff.

We reviewed three people's care records, which included care plans, health records, risk assessments and daily care records. We also looked at three staff recruitment files, staff training records and a selection of policies, procedures and records relating to the management of the service.

After our visit we sought feedback from relatives and health and social care professionals to obtain their views of the service provided to people. We received feedback from three relatives and one health care professional.

Good

Is the service safe?

Our findings

People told us they felt safe at the service and we observed they were relaxed in the presence of staff. People's family members said they felt people were safe at the service. Comments included, "The service is safe. [person] is well looked after" and "[Person] is safe there. They are looked after by the same staff and there are no changes."

A health care professional told us, "There is always enough staff when I have attended the service. People are well looked after by the staff and they get consistent care."

At the last inspection in December 2016, we identified a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to fully apply established recruitment systems to ensure all processes were embedded into practice.

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

There were robust recruitment checks in place to ensure staff employed were suitable to work in a health and social care environment. Staff recruitment files evidenced that two references, qualifications, identity checks and Disclosure and Barring Service (DBS) checks were completed before staff started to work unsupervised at the service. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. In addition, a member of staff had been employed since our last inspection and the recruitment process had been robust. This meant people were supported by staff that had undergone the necessary checks to ensure they were safe and suitable to work with people who may be vulnerable.

The registered manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff demonstrated an understanding of what might constitute as abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority and to the Care Quality Commission. Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people. This meant that people were protected by open and transparent safeguarding procedures.

There were enough skilled staff to support people with learning disabilities. We observed staff responding promptly to people's requests for support and to participate in activities. We reviewed rotas and saw that staffing levels were planned and consistent with what staff and the registered manager told us. They showed staff were deployed with a mixed skills set, with the registered manager, a team leader, senior care staff and experienced care staff available every week day. Staffing was adjusted to accommodate changes to people's

needs and depending on what activities people had planned. Absences were covered by regular staff to promote continuity of care and to ensure people's needs could be met by staff who understood them.

People were supported by staff who were aware of the risks to them on a daily basis. Staff we spoke with were able to describe the risks to particular individuals and how to manage those risks. For example, one member of staff said, "We need to be aware of people's moods and understand their needs. We actively engage them in activities they prefer as boredom can trigger behaviour that may challenge others." Individualised risks assessments were in place to identify the risks to people living at the service and when they went into the community. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, people had positive behaviour support plans in place for staff to follow if an incident occurred. A positive behaviour support plan is a document created to help understand and manage behaviour in adults who have learning disabilities and display behaviour that others may find challenging.

Where accidents or incidents took place, they were reported, recorded and fully investigated. Where appropriate, medical assistance was sought and body maps completed and any injuries sustained were recorded. Staff were aware of the procedures to follow in these circumstances and we saw evidence where incidents took place they were dealt with appropriately and information was passed onto colleagues via communication books and handover records.

People's medicines were managed so they took them safely. Appropriate arrangements were in place for obtaining medicines. The service received people's medicines from a local pharmacy on a monthly basis. Medicines were kept safely in a locked medicine cupboard in people's room, apart from one person, whose medicines were kept in a locked cupboard in the office. This was because the person was at risk of accessing the medicines and consuming these inappropriately, which could cause adverse effects on their health. The medicine cupboard was kept in an orderly way to reduce the possibility of mistakes happening. People were asked if they needed any medicines which were prescribed 'as needed' (known as PRN), such as pain relief. Medicines administration records (MAR) were appropriately signed by staff when administering people's medicines. Weekly audits were undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date.

People were protected by staff following good practice to prevent and control potential infection. For example, hand washing was thorough and staff had access to personal protective equipment, such as gloves, to reduce any possibility of cross contamination. Staff were allocated particular duties on a daily basis and checks were in place to ensure these tasks were completed. The premises were odour free. We observed the service to be clean and took people's personal preferences into account when it came to keeping their rooms clean and tidy. There was an infection control policy and staff received appropriate training in infection control and food hygiene. The registered manager completed infection control audits to ensure best practice guidelines were followed. Substances hazardous to health were kept securely within a locked cupboard in order to minimise the risk of people using them inappropriately.

The premises were adequately maintained through a maintenance programme to maintain safety. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care.

Arrangements were in place should an emergency occur which included an out of hour's policy, which enabled serious incidents affecting people's care to be dealt with at any time. There was an emergency grab

bag containing personal emergency evacuation plans (PEEPs) and other important information for people. There was also an emergency accommodation plan in place should the premises be inaccessible. This ensured that people could continue to receive safe and continuous care in case of emergencies.

Good

Is the service effective?

Our findings

People told us they were happy with the staff that supported them. Staff knew them by name. When asked if they liked the staff one person nodded in agreement and another smiled. People did not comment directly on whether they thought staff were well trained. However, we observed people were happy with the staff who supported them. A relative told us, "Staff attitude and approach is excellent."

A health care professional commented, "The staff are experienced and are very considerate to people's needs."

People's needs were assessed in line with their health and social care needs. Care records contained information about what was important to people, for example, important relationships people had that they needed support to maintain, people's hopes and aspirations, if they had any religious needs or followed any particular diets. Staff were able to describe to us how this information was collected and how important it was to be aware of it when supporting people. A member of staff described to us how they worked with each person living at the service. They told us, "We assess each individual and observe how they react to different situations, and work according to their needs." This meant that staff knew how to deliver the care people needed.

Each person had a health care passport with information relevant to their support needs, should they require admission to hospital. A health care passport provides personalised information in an easy to follow format to inform others about the person's needs. Health care needs were met in accordance with people's medical needs, for example, epilepsy and dysphagia. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. Records we looked at showed that all medical appointments were recorded. We found that people had access to doctors and other health and social care professionals as required, including specialist practitioners relating to their specific health conditions. For example, from a learning disability nurse, optician, dentist, chiropodist and epilepsy specialist. We also saw that any health care concerns were followed up in a timely manner with referrals to the relevant services. A health care professional described the care provided as "professional" adding that staff sought assistance appropriately and followed advice. Positive health was promoted through regular review of people's prescribed medicines. This meant that people's health and wellbeing was protected.

People's rights to make their own decisions were protected. Staff were aware of the need to gain consent from people before they delivered support. Throughout the inspection we observed staff listening and waiting for people to give their consent before supporting them to join in activities. Staff offered people choices about what they wanted to do, where they wanted to spend time, and what they had to eat and drink. One member of staff told us, "We support people to make choices by giving them options; they can all tell us what they want or don't want in their own ways. We get to know people well enough to know how best to communicate with them and read their body language." We observed staff interacted with people throughout the inspection and were aware of what people's non-verbal expressions meant.

People were supported to eat what, when and where they preferred. This demonstrated that people's rights were protected and their choices were respected by staff. A member of staff said, "People make their own food choices, we support them to go food shopping and they select what they want." Staff members took a lead in preparing the main evening meal which smelt lovely and those that were able, assisted staff in the kitchen, in order to enhance their independence and daily living skills. People were supported to eat by staff where required and people's specific dietary needs were catered for. Where a change in peoples dietary needs were identified, referrals were made to the necessary professionals. We saw records that showed that the provider had sought support from speech and language therapists (SALT) with regards to people's swallowing needs which can be addressed with specially prescribed diets. Staff were able to tell us about people's dietary needs and how they followed the guidance in place. There was detailed guidance in place for staff to follow for people who had specific health conditions, for example, epilepsy. The guidance contained detailed information, with known triggers and actions staff need to follow to ensure safe care and support is provided to people. Monitoring of seizures helped to inform medication reviews and to determine how well the epilepsy was managed.

Observations we made and records we saw showed that staff had the knowledge and skills they required to do their jobs. One relative told us, "I have no concerns at all; staff are well trained and experienced." Staff we spoke with told us that they received training to ensure they had the knowledge and the skills they required. There was a 12 week induction programme for new staff and staff told us that this prepared them with the knowledge and skills they required to care for people safely and effectively. One member of staff said, "The induction was good and prepared me well for the role. I shadowed senior staff before I could work on my own." New staff were supported and monitored throughout their probation period to ensure they had the knowledge and skills they required.

Staff received regular supervision meetings with either the team leader or registered manager, which provided an opportunity to discuss learning and development opportunities. Staff we spoke with told us that the registered manager was visible within the home and would offer constructive feedback and praise following observations of their work.

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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff had attended appropriate training and were able to explain how they applied the MCA 2005 in practice. Where people had DoLS authorisations in place CQC had been notified. The registered manager had a system in place to ensure where applicable DoLS applications were completed in a timely manner. This showed that the manager applied the principles of MCA 2005 within the home in a person centred manner which involved people in decisions about meeting their needs effectively.

Good

Is the service caring?

Our findings

People were supported by caring and kind staff who knew them well. We observed positive body language between people and staff, for example, people holding staff hands for reassurance and comfort. People were comfortable and relaxed amongst staff. Staff spoke to people using appropriate tones, body language, pointing and speaking slowly in order to engage with people. Staff acknowledged people when they went past them, addressed them by their preferred name and showed familiarity and respect in their approach to people.

A relative told us, "All staff are friendly, caring and always willing to help." Another relative said, "Staff are caring and helpful; I couldn't ask for better." A health care professional commented, "Staff are very nice and caring to all the people living at the service."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People receiving support had a learning disability and varying communication abilities. People were involved in all aspects of their care as far as reasonably possible and were supported to make day to day choices and staff made every effort to communicate with them in ways they could understand.

We saw staff communicating with different people using different methods for example, Makaton, signs and gestures. We saw information was presented to people in various formats in accordance with their needs. Written information was available and was accompanied by pictorial illustrations to aid understanding. Verbal communication was consistently accompanied by gestural prompts or objects of reference to further support people's understanding of questions, choices and instruction. This collectively enabled people to be more involved and promoted their autonomy and independence within the home. Care plans provided staff with the information needed to communicate effectively with people. For example, for people who were unable to communicate verbally, information was available which guided staff as to how someone was feeling such as how to tell they were happy, unhappy, tired, angry, hungry, etc. This additional information provided staff with the tools to communicate effectively with people and respond to their needs in a timely manner.

People received both practical and emotional support from staff at all times and were treated as individuals. Staff adopted a positive approach in the way they involved people and respected their independence. Staff supported people in an empathic way. When a person expressed anxiety and distress staff immediately provided reassurance and support. Staff knew people extremely well and were able to tell us about different people's care needs, any associated risks as well as their hobbies, interests, likes, dislikes and preferences. We saw that people were supported to follow their hobbies and activity schedules were tailored to meet their interests and preferred routines. For example, people were supported to go swimming, keep contact with their families or enjoyed going out for local walks or engaging in indoor activities. People were supported to maintain their individual differences in relation to their personal appearance and style preferences. A relative told us, "[Person] always looks clean and well presented."

People were supported to express their views through monthly one to one well-being meetings with the team leader. We saw these meetings provided people with the opportunity to discuss any concerns they may have, how they were doing and their plans for the coming month. People were supported to plan their activities and staff rotas were adjusted in conjunction with these plans, to ensure the correct number of skilled staff were available on each shift to support people to take part in activities they had chosen.

People were treated with dignity and respect. We saw staff respected people's choices and autonomy within the home and spoke to people respectfully with kindness and compassion. Relatives we spoke with told us that this level of courtesy was extended to them also, and their input and relationships with their loved ones was valued. One relative said, "I am always made to feel welcome when I am visiting." Personal relationships were actively supported. The registered manager and staff understood the importance of relationships with friends and family and did what they could to support people. For example, by supporting people to maintain regular contact with their family and friends and facilitating visits to their family.

Staff treated people with dignity and respect when helping them with daily living tasks. People's bedrooms gave them privacy and space to spend time on their own if they wished. Bedrooms reflected people's specific interests, such as pictures and posters on the walls. Staff and relatives we spoke with confirmed that people were supported to make decisions and choices about the decoration of their room.

Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff promoted people's equality, diversity and ensured their human rights were upheld. For example, by giving people choice, encouraging them to do as much as they could for themselves and providing care and support in the least restrictive way.

Good

Is the service responsive?

Our findings

People received the care and support they needed and staff were responsive to their needs. Some people using the service had lived there for many years. People were supported to be involved in their care and support if they wanted to. Staff worked around their wishes and preferences on a daily basis. People said or indicated to staff about the care and support they wanted and how they preferred to have things done.

People were treated as individuals and their personal likes, dislikes, preferences and daily routines were respected and promoted. People and those that were closest to them alongside any relevant health and social care professionals were involved in the planning and review of their care, to ensure that care was specific to their individual needs, preferences and person-centred. One relative we spoke with said, "We are involved in all review meetings and have the opportunity to contribute to these. The staff also keep us updated on any changes or appointments".

Each person had a care plan and health care file, which was regularly reviewed, taking into account the person's wishes and information from people who knew them best, such as family members and external professionals. Care files included personal information and identified the relevant people involved in people's care, such as their GP, psychiatrist or SALT. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. They were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. Staff said that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Activities were led by people and were flexible in order to meet people's needs. We saw people engaged in activities that they had identified as meaningful and important to them and staff supported people to spend as much time as possible doing the things they enjoyed. We found that people benefitted from structured daily routines, which stimulated their minds and offered opportunities for social engagement. Staff told us that people enjoyed activities indoors as well as outside of the home including, going shopping, swimming, visiting animal farms and day trips. We saw people enjoying interactive and more passive activities within the home including watching television and self-directed activity with objects of meaning. One member of staff said, "[Person] loves beads and likes to play with these". Relatives we spoke with told us staff were enthusiastic and encouraged people to get involved in activities.

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff on a regular and informal basis. Relatives were also made aware of the complaints system. Everyone we spoke with told us that they knew how to complain and they were confident that their concerns would be dealt with appropriately. The

complaints procedure set out the process which would be followed by the provider and included contact details of the provider and CQC. This ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints in the last 12 months. However, the registered manager recognised that if they received a complaint, they would respond to it in line with the provider's procedure.

Good

Is the service well-led?

Our findings

Everyone we spoke with were complimentary of the management of the service. Comments we received from relatives included, "Management is excellent; they keep us informed", "The service is well-run" and "Management is visible and approachable."

Staff said, "The registered manager and team leader are both very supportive and approachable", "We receive regular feedback on our performance and areas where we need to improve" and "It is a good place to work."

The service had a registered manager in post as required. The registered manager was also the registered manager at sister services and explained that they split their time equally between the services they managed, although if one service needed more input at a particular time, they would spend more time there. The registered manager was supported by a team leader and senior care staff in the day to day management of the service. The registered manager was familiar with their responsibilities and conditions of registration. Providers are required by law to inform us of certain events that happen within the home (such as serious injuries, safeguarding concerns or deaths). The management team at the service provided a good balance of skills, experience and knowledge.

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

There were systems in place for auditing and monitoring the service. The registered manager undertook a range of checks and audits on the home and the delivery of care. There were a range of measures in place to ensure care delivery was safe and effective. Audits carried out included infection control, environmental checks, medicines, care plans, daily records and health and safety. Where areas required attention, actions had been taken. For example, we saw the downstairs bathroom door was in need of replacement. This had already been identified by the registered manager and was due to be replaced over the coming weeks. These helped to make sure people received a good standard of care and support, which was in accordance with up to date good practice guidance.

Recruitment procedures had been reviewed and were robust. There were detailed guidance in place for staff to follow when supporting people with specific health conditions, like epilepsy or dysphagia.

We found that there was an open-minded and inclusive culture within the service whereby everyone was respected for their contributions and differences. People's equality, diversity and human rights were respected. The service's vision and values centred around the people they supported. No-one we spoke with raised any concerns about bullying or harassment within the workplace and staff we spoke with told us that everyone was treated equally and fairly. There were a range of policies and procedures in place that

gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed.

There were system in place to involve people in the development of the service. A member of staff said, "We have regular staff meetings and everyone has the opportunity to discuss things and changes are then made." We saw that staff views were sought on the service and their voice was listened to. For example, staff said that on occasions when people had been unwell and unsettled during the night, they were finding it hard to carry on working on a morning shift following a disturbed sleep-in shift. This was raised at a staff meeting and the registered manager agreed that staff could go home if they carried out a waking night instead of sleep-in duty, due to changes people's support needs during night time. Staff were confident their ideas and suggestions would be taken into account in further development of the service.

Staff confirmed they were kept up to date with things affecting the overall service via staff meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change. A relative also commented that they found communication between the home and them was very good.

The registered manager worked closely and in partnership with external agencies. We saw records which evidenced partnership with external professionals. For example, with specialist learning disability services and health professionals such as physiotherapists, speech and language therapists and dieticians, all of whom supported the development of staffs skill and knowledge. The registered manager told us they kept up to date with changes in practice through the Skills for Care website, CQC newsletter for providers and registered managers' forums.

People were enabled to express their views during day to day contact with staff, monthly well-being meetings with the team leader and annual reviews. These meetings were all documented in an accessible format that people could understand and shared with people that mattered to them.

Providers are also required by law to display their CQC rating awarded at their most recent inspection. We saw the provider had displayed the rating of our last inspection in the communal area of the home. This was seen to be conspicuous and legible as required.