Care Quality Commission

Caretech Community Services (No 2) Limited

Kingston House

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?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection was unannounced. At the previous inspection in November 2013, we found that there were no breaches of legal requirements.

Kingston House provides accommodation and personal care for up to nine adults with a learning disability. There were six people living at the home at the time of inspection, including older people with complex care needs. The accommodation is over two floors, but everyone had a downstairs bedroom as people were either wheelchair users or were not able to manage the stairs safely. There was a communal lounge, dining room and a garden with seating.

The home was run by a registered manager who was present on the day of our visit. 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.

The provider had taken steps to make sure that people were safeguarded from abuse and protected from risk of harm. Staff had been trained in safeguarding adults and knew what action to take in the event of any suspicion of abuse. Professionals told us that people were cared for in a way that ensured their safety.

Risks to people's safety were assessed and managed appropriately. Assessments identified people's specific

Summary of findings

needs, and showed how risks could be minimised. The manager also carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was in good working order. There were systems in place to review accidents and incidents and make any relevant improvements as a result.

Medicines were managed and administered appropriately. People received their medicines as intended by their doctor.

The provider was effective in monitoring people's health needs and seeking professing advice when it was required. Health care professionals said that staff always followed the advice that they gave. Assessments were made to identify people at risk of poor nutrition and for other medical conditions that affected their health.

People were supported to have a nutritious diet. A lot of care was taken by staff to make sure that people had enough time to enjoy their meals. Meal times were managed effectively to make sure that people received the support and attention they needed.

New staff received a comprehensive induction, which included shadowing more senior staff and an individual introduction to the care needs of each person at the home. Staff had regular training and additional specialist training to make sure that they had the right knowledge and skills to meet people's needs effectively.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. Care plans contained mental capacity assessments and DoLS applications had been made for everyone who lived in the home to ensure that people were not deprived of their liberty.

People's care, treatment and support needs were clearly identified in their plans of care. They included peoples choices and preferences. Staff knew people well and understood their likes and dislikes. Particular attention was paid to all staff understanding people's past histories. Staff treated people with kindness, respect and compassion. Relatives and visitors all commented on the caring nature of the home and the positive relationships between staff and people who lived at the home.

People were offered an appropriate range of activities. As most people were not able to go out into the community on a regular basis due to their health, the home ensured that people from the community visited on a regular basis. Activities focused on sensory activities such as aromatherapy, crafts and music.

The home was well led. Relatives and visiting professionals told us that the manager was approachable and that they could drop in at any time. Staff understood the aims of the home, their roles, were motivated and had confidence in the management of the home. They said that there was good communication in the staff team and everyone helped each other, which was essential to the effective running of the home. There was a core team of staff who had worked at the home for a number of years and a low staff turnover.

Quality assurance systems were robust and there was a culture of continuous improvement. There were systems in place to review the quality of all aspects of the service regularly. This was carried out by the registered manager and two representatives from the company. Improvement plans were developed where any shortfalls were identified and continuously monitored to make sure that improvements were made and sustained.

The provider sought feedback from people and their representatives by using a quality questionnaire. These were sent by the registered manager and also separately by the company. The results of these surveys were that everyone was satisfied with the care provided at the home and people rated aspects as 'good' or 'excellent'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were enough staff to meet people's needs.

The provider had taken steps to protect people from abuse and operated safe recruitment procedures. Medicines were administered, stored and recorded appropriately.

Risks to people's safety and welfare were assessed and managed effectively. The home and its equipment were checked regularly to ensure that they were maintained.

Good

Is the service effective?
The service was effective.

Staff had regular training to ensure that they had the skills and knowledge to meet people's needs. Staff were aware of the requirements of the Mental Capacity Act 2005 and understood how to protect people's rights.

People were supported to eat and drink and were protected from the risk of malnutrition or dehydration. Meal times were managed effectively to make sure that people received the support and attention they needed.

The home liaised with other healthcare professionals to maintain people's well-being.

Good

Is the service caring?
The service was caring.

Staff knew people extremely well. They understood from their body language if they were content, upset or unsettled. Staff communicated with people in an individual manner and treated people with dignity and kindness. Staff explained things in a way people could understand at all times.

Relatives were included in making decisions about people's care.

Outstanding

Is the service responsive?
The service was responsive.

People received care or treatment when they needed it. Staff were knowledgeable about people's support needs, interests and preferences, in order to provide personalised care.

People were offered a range of suitable activities and were visited by people from the local community.

Information about how to make a complaint was clearly displayed in the home in a variety of suitable formats and staff knew how to respond to any concerns that were raised.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The manager was approachable and there was good communication within the staff team. Professionals said that they could visit at any time. All staff understood their roles and responsibilities.

Staff, people and their visitors were regularly asked for their views about the service. Staff had a clear vision of the home and its values and these were put into practice. They ensured that people were at the centre of everything that they did.

Quality assurance and monitoring systems ensured that any shortfalls or areas of weakness were identified and addressed promptly to ensure that a consistently high level of service was maintained.

Kingston House

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 26 November and was unannounced. One inspector carried out the inspection because it was a small home with six people living there. Therefore, it was inappropriate to include additional people in the inspection team.

Prior to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete 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. The provider returned a PIR within the set time scale. We also obtained feedback from a care manager from social services, speech and language therapist, physiotherapist and an independent mental capacity advocate (IMCA). An advocate is someone who can help people express their needs and wishes, by supporting people to speak, or by speaking on the person's behalf. They can weigh up and take decisions about the options that are available to people.

Most people were not able to tell to us about their experience of living in the home. We talked with one person who lived in the home and observed staff helping people with food and drink at mealtimes, supporting people in the lounge and talking with people during the day. We spoke to the registered manager and three staff, including care staff and senior care staff. We also saw the communal areas of the home and three bedrooms. We spoke with staff about the care needs of two people who lived at the home, looked at their care plans and observed how staff supported them. This enabled us to see how people's care was planned and delivered.

During the inspection we viewed a number of records including three care plans, two staff recruitment records, the staff training programme, staff rota, medicine records, environment and health and safety records, risk assessments, staff team minutes, menus, compliments and complaints logs and quality assurance questionnaires.

Is the service safe?

Our findings

People received support from staff in a way that ensured their safety. Staff were relaxed and not rushed when helping people with everyday tasks. We observed that staff talk to people and look at their body language in order to respond appropriately and to keep people safe. Compliments from relatives feedback from health and social care professionals confirmed that people were cared for in a way that ensured that their safety.

The provider had taken steps to help protect people from abuse. All staff had received training in how to recognise and respond to the signs of abuse. Staff said that training included information about the different types of abuse and the signs to look for to indicate that abuse may have taken place. They said that they knew to report any concerns to the registered manager. They said that they felt confident that they would be listened to, but that if their concerns were not taken seriously, they said that they would refer them to the local authority, Care Quality Commission or the police.

Staff demonstrated that they knew how to "blow the whistle". This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. The company had a whistle blowing free phone line and an email address to enable staff to share their concerns in a safe way with non-operational management staff. Staff understood which member of staff to talk to and that they could speak to the company director. They said that they had the contact details, so that there would be no delay in reporting any serious concerns and so keep people safe.

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as nutrition, mobility and skin integrity. They included clear guidance for staff about any action they needed to take to make sure people were protected from harm. For one person it had been assessed that they were at risk of choking when eating. Detailed mealtime guidelines were in place giving clear directions to staff about how to support the person to eat. This included that they needed to use a spoon and how they needed their food to be prepared. Staff were knowledgeable about these guidelines and we saw them putting them into practice at breakfast and lunchtime. Risk assessments were regularly reviewed and when people's needs changed, to ensure that they contained up to date guidance.

The registered manager carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was fit for use. These included making sure that the water was maintained at a safe temperature, that fire equipment was in working order, that the risk of a potential fire occurring had been minimised and that electrical and gas appliances at the home were safe. An external company had carried out a health and safety audit in January 2014 and action had been taken to address any shortfalls. The kitchen had been visited by the Environmental Health Officer in 2013, and had been awarded the highest rating of five stars for food hygiene.

Signs with pictures were used throughout the home to assist people with needs associated with living with dementia and a learning disability, to find their way around the home.

Each person had a personal emergency evacuation plan (PEEP), which set out the specific physical and emotional requirements that each person had to ensure that they were safely evacuated from the home in the event of a fire, both during the day and at night. Environmental risk assessments were also in place to minimise the risks of people living and working in the home from hazards such as slips, trips and falls.

Accidents and incidents were reported to and monitored by the registered manager. Information about accidents and incidents were also sent to the company's head office, so that they could monitor the service and ensure that staff took the appropriate action.

Staff were used flexibly to ensure that there were enough staff on duty at all times. Staff said that there were enough staff available to meet the needs of the people who lived at the home. Six people lived there and four people used a specialist wheelchair and required two members of staff to support them with their personal care and any transfers in and out of their wheelchairs. There were three staff on duty each day, including a senior care staff member. Therefore, when two staff were supporting one person, there was always another member of staff available. Our observations were that the pace of the home was relaxed, people were

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not rushed to get up in the morning, and they were given one to one attention at mealtimes. At night time there were two waking night staff. This ensured that people were checked every hour and supported to be repositioned in their beds to maintain healthy skin.

Practices to recruit new staff were robust. People interested in applying for a position at the home provided the registered manager with information about their past employment history and skills. If the person met the criteria, they completed an application form and attend an interview at the home. At the interview applicants were asked a complete a short written test and to answer a number of standard questions to ensure that each applicant was treated fairly. If the person was successful, the manager checked the applicant's work history, references and undertook identification checks. All the information was then sent to head office who understood reference checks and criminal record/barring and vetting checks. Therefore, all checks had been carried out to ensure the applicant was a suitable person, before they started work at the home.

Medicines were stored securely in a locked cupboard. All the medicines that we saw were in date. Medicines with a short shelf life, such as creams, were routinely dated on opening and this was also recorded on a separate record. This was to make sure that they were given before they became unsuitable to administer.

Medicines were received into the home from a pharmacy each month. Senior staff checked all medicines to ensure that they matched with the medication administration record (MAR) printed by the pharmacy. This took place on the day of our visit and was carried out in a professional and methodical manner to minimise the risk of any errors being made. Most medicines were administered using a monitored dosage system of "blister packs". This meant that the name of the medicine and the person for whom it was prescribed was written on each medication. This helped to ensure that people were given the right medicine as prescribed by their doctor.

Details were kept of each person's requirements in relation to their medicines. This included what people's medicines were for, any side effects to look out for and how they took their medicines, such as on a spoon or with food. Medication administration records (MAR) were clearly and accurately completed and clear guidance was in place for people who took medicines prescribed as and when required (PRN).

Is the service effective?

Our findings

The days menu was displayed on the dining room wall with photos of each meal to inform people of what was available and to help people make choices. One person pointed to the photographs of breakfast cereals and told us which one they liked to eat.

People were supported in maintaining a balanced and nutritious diet. There was a four weekly menu with meal options. We saw that at mealtimes people ate different meals according to their needs and preferences. There was a list of people's likes, dislikes, allergies and what foods people were not able to eat because of swallowing difficulties. There were also detailed plans of the support that people with swallowing difficulties needed at each meal time. All this information was kept in the kitchen as well as in people's support plans so that it was available to staff at all times. Staff understood people's eating and drinking needs. They knew who had their food pureed, who required fortified foods and the exact consistency that people needed their fluids thickened.

People ate their meals in the dining room. This was encouraged to enable people to socialise. We observed part of breakfast and joined people at lunchtime. People were supported to eat at their own pace. Staff talked with people during mealtimes and explained what they were going to eat. Staff also observed people's reactions to eating and drinking to ensure they supported them to eat at the correct speed. Staff showed patience towards people who took time to eat their meals and we saw from people's facial expressions that both staff and people gained satisfaction out of the positive experience.

There were reliable procedures in place to monitor people's health needs. People's care plans gave clear written guidance about people's health needs. Each person also had a "My Keeping Health Plan" which set out in more detail each person's health needs and the action that had been taken to assess and monitor them. This included details of people's skin care, eye care, and needs concerning people's mobility. A record was made of all health care appointments including why the person needed the visit and the outcome and any recommendations. People's weights were recorded on a monthly basis so that prompt action could be taken to address any significant weight loss, such as contacting the dietician or doctor for advice.

The home had close, supportive links with health care professionals, including physiotherapist, speech and language therapist, occupational therapist and chiropodist. All health care professionals we spoke with gave positive feedback about their involvement in the home. They said that the registered manager always contacted them with any queries, that timely and relevant referrals were made, and that any guidelines given were always followed and monitored.

New staff received a four day external induction which covered an introduction to the company and training in the skills that they required for their role. Staff completed a workbook, based on Skills for Care's "Common Induction Standards (CIS)".CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. New staff also shadowed senior staff undertaking care with each person who lived in the home. This was to ensure that new staff had the skills and competence to care for each person's individual and complex needs. Some staff had completed or were working towards Diploma/Qualification and Credit Framework (QCF) level two and three. These build on the common induction standards and are nationally recognised qualifications which demonstrate staff's competence in health and social care.

Support for staff was achieved through individual supervision sessions every one or two months with the registered manager. Staff told us that supervision was effective as it was an open forum where they could seek advice and discuss any concerns. At supervisions any actions identified were followed up. Supervision sessions were planned in advance and information about the dates was displayed on the office wall so that it was available to the staff team.

Staff told us that they received monthly updates when they were required to refresh their training. Most training was undertaken on a computer and staff said that it was comprehensive. Moving and handling and first aid training was class room based. There was an on-going programme of development to make sure that all staff were kept up to date with required training subjects. These included health and safety, fire awareness, moving and handling, emergency first aid, infection control, safeguarding, dementia and nutrition. Specialist training had been provided by the physiotherapist in chest physiotherapy. This is a technique used to loosen secretions in the lungs

Is the service effective?

for people with large secretions or whose cough is not effective in clearing these secretions. The speech and language therapist had provided staff training in feeding people with a PEG tube (percutaneous endoscopic gastrostomy). PEG is a tube that feeds directly into a person's stomach. Professionals said that staff were competent in their skills, keen to learn and that the registered manager was good at letting them know when new staff needed more training.

Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People's mental capacity had been taken into consideration when planning their care needs. Where people did not have capacity to make decisions such as how to take their medicines or how to sit safely and comfortably in their wheelchair, best interest meetings had been held. These meetings where held with relevant professionals and relatives and a decision was made on a person's behalf and in their best interests.

The manager understood the principles of the Mental Capacity Act 2005. They explained that people's capacity in the home, to understand and retain information, could fluctuate due to their dementia and understanding. They had made applications for Deprivation of Liberty Safeguarding for all the people at the home. These applications varied according to people's capacity. They included making sure that people using harnesses for their wheelchair were not unnecessarily restricted. People living with dementia could not leave the premises without the staff support that they required to remain safe. These applications ensured that an independent assessment would be made as to whether these people were being deprived of their liberty. Health care professionals told us that the staff were proactive in contacting them to ensure that care was provided in people's best interests and that it did not deprive them unnecessarily of their freedom.

Is the service caring?

Our findings

The staff team had received a lot of compliments from relatives about the caring nature of the home. Compliments included, "Thank you all the staff for the excellent care being given to my relative"; "Staff members very friendly and thoughtful, very warm and well caring"; and, "We are vey impressed by the care we see in action. Our hope is that all homes would give the kind of special care my relative receives". A visitor to the home commented, "I personally believe this home to be one of my favourites".

Visiting health and social care professionals said that when they visited the home they were always greeted with a warm welcome. They commented on the "exceptional" caring nature that was present at the home and that staff were highly motivated. One person told us, "I am very impressed with the caring and dedicated attitude of the staff and they appear to be a solid team and well supported by the registered manager". Professionals told us that staff "really care" about the people that they support. One professional told us, "I see genuine relationships between staff and people". They said that when people were unwell or in pain, staff were affected emotionally. They ensured that people were continually reassured by talking to them and making them aware of their presence, as well as making them physically comfortable.

Throughout the day we saw staff communicated with people in a kind, attentive and compassionate manner. People were the centre of how each day was organised. Staff explained how each day was different, depending on each person's well being. Sometimes people were alert and ready to get up and have breakfast. On other days people were more sleepy and people were left to sleep longer in the morning and more time was taken to support people to eat their breakfast. People got up at different times and we heard staff talking with people commenting that they were a bit sleepy or that they were enjoying their food or what they were doing. This was because staff understood people's mood and well- being and body language.

The views and opinions of people were recorded in detail in people's care plans. This was particularly important as some people's needs had deteriorated since moving to the home and they were unable to express their views verbally. Care plans contained very detailed information about people's life history including where they used to live, what they liked to do and people who were important to them. These life histories were written in the form of a story and used pictures to give a full account of people's lives before and after they moved to the home. This picture format also helped people to understand some aspects of their plan of care. DVD's (digital versatile disks) of people were also available. This enabled new staff to understand people's character, interests and abilities, before their health deteriorated, and so helped them to support people to make decisions in their best interests, on a day to day basis.

Staff supported people to be as independent as possible. They explained that one person who was living with dementia liked to make their own breakfast. We saw that staff stood back while this person made their breakfast by themselves. Staff gave support when it was required, in a friendly, positive way, so that the person still felt in control of the situation.

Where people did not have the capacity to make their own decisions and no relatives to represent them, the staff involved independent mental capacity advocates (IMCA). An IMCA told us that many of the staff team had supported people at the home for a long time and knew them very well. They said that staff were "absolutely dedicated" to the care of the people living there and that they put their needs and wishes first. The IMCA was involved in a decision about whether a person should have a PEG tube fitted. The IMCA said that the staff put the needs and wishes of the person first when making this decision. Everyone agreed that artificial feeding would not be in the person's best interests as they had shown and continued to show how much they enjoyed eating their own food.

Health and social care professionals told us treating people with dignity and respect was central to the philosophy of the home. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity. Staff knew the actions that they needed to take to put this into practice. This included explaining to people what they were doing before they carried out each personal care task. Some people were not able to respond with words, but staff responded to people's body language. Staff explained that Care plans also included what actions staff should take if they knocked on a person's door and they were unable to answer. Staff put this guidance into practice on the day of

Is the service caring?

our visit. People and their family were involved in developing end of life care plans. These plans contained information about where the person would like to be cared for if their health deteriorated and arrangements for their funeral. This included people's individual wishes such as what music they would like to be played at their funeral and where they would like to be buried. Health professionals told us that when people at the home were receiving end of life care, the staff were "fantastic" at ensuring people got the care that they needed. They said in these circumstances staff were good at advocating on behalf of people and ensuring that their rights were upheld. They told us that when one person was admitted to hospital, the staff team ensured that there was always someone with them. This meant they had a familiar face around them who understood their needs, even if they could not verbalise them.

Is the service responsive?

Our findings

Relatives were involved in the planning and review of their relatives care. Health and social care professionals told us that the service was responsive to people's individual and changing needs. For example, when one person moved to the home they did not take part in a daily activity which was beneficial to them. Staff developed a programme to gently support and encourage this person to take part in the activity, for short periods at a time. Records showed that they were now a full participant. We saw this person engage in the daily activity whilst speaking confidently to other people and staff members. There was a picture of the person achieving their goal in their care plan and also within the home, to show how important it was to the person and the staff team.

The policy of the company is that people's needs were assessed before they moved into the home, and that an assessment was obtained from the local authority so that a joint decision could be made about how people's individual needs could be met. The registered manager told us that the most recent people who moved to the home did so as emergency admissions. The local authority assessment was obtained before the person moved to the home and people's relatives visited the home to discuss their care needs in more detail. These assessments formed the basis of each person's plan of care.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs to enable staff to care for each person. They included guidance about peoples' daily routines, communication, continence, skin care, eating and drinking, health, medication and activities that they enjoyed. People's care plans were reviewed monthly and a summary was undertaken of their care needs to ensure that staff had the correct guidance to follow.

Most of the people were not able to communicate through using speech and used body language and facial expressions to let staff know how they were feeling. Staff explained how they looked out for changes in people's body language and facial expressions to identify any changes in their health and well being. The complaints policy was displayed on the wall by the entrance to the home. One policy was for people who lived at the home. It displayed a number of pictures, such as food, home, transport and sad and smiley faces to aid people to explain what their concerns may be about. The registered manager explained that if people's body language indicated that they were upset, they would be given these pictures so that they could point to what was upsetting them. There was also information about how to contact the advocacy service. A complaints policy for visitors and relatives was also available. This included information about how to contact the ombudsman, if they were not satisfied with how the home responded to any complaint. An ombudsman is an independent person, who is charged with representing the interests of the public by investigating and addressing complaints. Staff explained how they would respond to a compliant to ensure that people's views were heard and acted upon. The complaints log showed that there had not been any complaints about the home during the last year. Feedback from relatives in the home's quality assurance survey confirmed that relatives knew how to make a complaint, but that they had not needed to do so.

Is the service well-led?

Our findings

Relatives and health and social care professionals told us that the home was well led. They said that the registered manager had an open door policy where they welcomed family and professionals to drop in without an appointment. When they visited they said that they always received a warm welcome. Health and social care professionals commented that the registered manager was "proactive" in ensuring that people received the individual care and treatment that they required. People's relatives had commented through feedback forms to the home, that they were impressed and pleased to have their relative living in such a caring environment.

The registered manager and staff were clear about the aims of the home which were for people to live an ordinary home life, in a homely environment, to have relationships, and to be part of the community. There was a picture of the aims of the home on the downstairs wall, which showed a personal relaxing in their own chair and looking content and comfortable. The registered manager led by example. When they spoke about people, they were very clear about putting people first. We observed that the registered manager knew people well, communicated with people in a way that they could understand and gave individual and compassionate care. The staff team followed their lead and interacted with people in the same caring manner.

Staff said that there was good communication in the staff team and that everyone helped one another. They said that the home could only operate for the benefit of the people who lived in it with good team support. Staff said that it was a good place to work and that they enjoyed their jobs. Staff said that the manager was available and accessible and gave practical support, assistance and advice. Staff were supported through regular staff meetings and individual supervision. Staff handovers between shifts highlighted any changes in people's health and care needs. If staff had any concerns they could approach the manager straight away.

There was a low turnover of staff at the home which meant that staff had known people for a long time. A healthcare professional commented that the core staff team had remained the same for the last seven years. This benefitted people as staff knew people's past histories and likes and dislikes and were able to promote these. An IMCA said that staff were strong advocates for the people who lived in the home.

Some people had come to live at the home in an emergency. Their relatives and social care professionals commented on how well the home had supported these people in these difficult circumstances. In the home's quality assurance survey a relative commented that their relative was, "Settling into Kingston House. They were up and dancing just like they used to". A social care professional wrote a letter to the manager about a person they had placed at the home. "I cannot imagine them being in a better place. How wonderful to see how they have accepted their home and confidence in you and your staff give him. Coming up to one year. What a remarkable turn around".

People's views were sought through survey questionnaires. The company had recently sent questionnaires to people's relatives, friends and advocates. At the time of our visit four had been returned. Responses were that people were getting good or excellent care at the home. One person commented about their relative, "As their condition gradually deteriorates, they receive all the appropriate care and consideration. We feel they could not be in better hands!" The home also carried out its own survey in 2014 to gain the views of people who visited. The responses were all very positive about the care that people received. A relative commented, "This is an excellent home" and a visitor commented, "Staff are very kind and helpful".

There were effective systems in place to was regularly monitor the quality of service that was provided. The registered manager audited aspects of care monthly such as medication, care plans, health and safety, infection control, fire and equipment. The locality manager visited monthly to check that all audits had been carried out. They completed an improvement plan which set out any shortfalls that they had identified on their visit. This plan was reviewed at each visit to ensure that appropriate action had been taken. The compliance and regulation manager from the company visited the home twice a year. During their visit they looked at records, talked to people and staff and observed the care practice in the home. A detailed report was produced about all aspects of care and treatment at the home. It identified any shortfalls which were added to the homes' improvement plan so that they

Is the service well-led?

could be reviewed monthly by the locality manager. The report highlighted updating care plans, referring deprivation of liberty safeguards to the local authority, and for the manager and staff team to attend personalisation training. In addition the companies finance department visited twice a year. They also produced a written report and we saw that all actions that they had suggested, had been implemented in the home.