Richmond Fellowship (The)

Trevayler

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 & 18 April 2018. The visit on 12 April was unannounced; the second visit was announced as we required the registered manager to be in the office to assist with the inspection.

There was a registered manager was in post. 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.

Trevayler is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The inspection was a first rating inspection following a change of registration.

The provider carried out quality monitoring checks in the home supported by the registered manager and home's staff. The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours if an emergency arose, or an equipment repair was necessary. Staff had access to the maintenance diary to manage any emergency repairs. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people who used the service.

We found that no applications were required to be made to the local authority to legally deprive people of their liberty, as all people admitted had capacity. The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. They were also aware where best interests meetings would be planned to ensure people's treatment was in line with the MCA and Deprivation of Liberty Safeguards. People were asked for their written consent to care following their admission to the home. Although care plans were all held electronically people were still encouraged to sign these electronically.

Following their recruitment staff received on-going support and training for their job role. Staff were able to explain how they kept people safe from abuse, and were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse. Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home.

People were supported to continue with their chosen dietary and cultural needs. Staff supported people to undertake a range of activities that were tailored to people's interests and needs. Staff had access to information and through this had developed a good understanding of people's care and support needs. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

People were involved in the review of their care and support plan. Staff had access to people's support plans and received regular updates about people's care and support needs. Care and support plans were updated to include changes to peoples care and treatment. People were offered and attended routine health checks, with health professionals both in the home and externally.

We observed staff interacted positively with people throughout the inspection, people were offered choices and their decisions were respected.

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.

Care plans included risk assessments and informed staff of areas where people required support to ensure their safety. Staff understood their responsibility to report any observed or suspected abuse. Staff were recruited and employed in numbers to protect people. People were protected from infection by control measures being put in place. The staff employed provided a culturally appropriate service.

Medicines were ordered and stored safely. However PRN protocols and some missed signatures detracted from the overall safety of medicines.

Is the service effective?

Good

The service was effective.

Staff had completed essential training to meet people's needs safely and to a suitable standard. People received appropriate support and guidance that prompted people to continue a well-balanced diet that met their nutritional and cultural needs. Staff understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care or counselling before it was provided.

Is the service caring?

Good

The service was caring.

Staff were caring and kind, treated people as individuals and recognised their privacy and dignity at all times. Staff understood the importance of providing care and support for people in a dignified way. People were encouraged to make choices and were fully involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support that met their

needs. People were involved in planning how they were supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People were confident to raise concerns or make a formal complaint if necessary. People were supported to have a dignified and pain free death.

Is the service well-led?

Good

The service was well led.

Quality audits and checks were used to ensure people were provided with good safe care and support. There was a registered manager in post. People who used the service had regular opportunities to share their views and influence the development of the service.

Trevayler

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.

The inspection was a first rating inspection following a change of registration.

Inspection site visit activity started on 12 April 2018 and ended on 18 April 2018. It included direct observations of the staff group and how they offered care and support to people, speaking with the people, the management staff and a visiting health professional. We visited the office location on 12 April to speak with the registered manager and staff; and to review care records and policies and procedures.

The inspection on 12 April was unannounced and was carried out by one inspector and a specialist adviser. The specialist advisor we used had a professional qualification and expertise in care and nursing. The inspector returned alone on 18 April and this visit was announced

Before the inspection visit we looked at the information we held about Trevayler including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) and other observations to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who cannot talk with us.

We spoke with four people who live at the home to gain their experiences of Trevayler. We were assisted on the inspection by the registered manager, team leader and recovery workers. We asked the registered manager to supply us with information that showed how they managed the service, some of which we

received following the inspection visit. We also spoke with three recovery workers.

We looked at three people's care plan records in the care home and one person who used the domiciliary care support to see how they were supported to regain or maintain their wellbeing. We looked at other records related to people's care such as medicine records, daily records and risk assessments. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Good

Is the service safe?

Our findings

People told us they felt safe in the home and were safeguarded from abuse. Staff we spoke with understood their responsibilities to keep people safe. Staff confirmed they had received training and were enabled to recognise when people may be at risk of harm. Staff were able to explain what they would do if they suspected or witnessed abuse of any person who used the service. They told us they would share their concerns with the registered manager or team leader. One member of staff told us, "I would bring it to the manager's attention, if the situation was not being dealt with, I would go to the head office or report it to safeguarding and CQC." A second member of staff said, "I would have no hesitation with informing the manager." This demonstrated that the provider had taken steps to ensure people were safeguarded from harm.

Care plans and associated risk assessments were regularly updated and identified the risks to people's health and wellbeing. The care plans provided clear guidance for staff in respect of minimising risk.

Staff were aware of the support people required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. People's care records included the activities related to their health, safety, care and welfare and a wellness recovery action plan (WRAP). The WRAP was developed following a risk assessment and identified key areas that the person felt necessary to improve their mental health and well-being to the point of regaining their stability.

People were observed to be interacting well with staff members, there was no hesitation by people to approach staff when requiring assistance. There were therapeutic relationships, between staff and residents. The therapeutic relationship is central to providing care to people who experience mental health and physical health problems, which can be the primary intervention to promote awareness, trust and to enrich a resident's living experience within the home environment. One person came to the office, staff were observed to assist with the services user's enquiry and there were open questions in relation to establishing how the person was feeling and had they enjoyed themselves whilst out within the community setting.

We observed people were relaxed when staff offered assistance and support to them, which indicates people were comfortable with the staff group.

The home had a safe environment. The registered manager spoke about the need for an environment that was safe for people to live in. The home supported people, some of whom have previously attempted to take their own life. The environment of the home has been risk assessed thoroughly and though it is not ligature free the staff have followed the company guidance and made the environment as safe as it can be. Staff were regularly reminded about people's safety, safety around the environment and their personal safety. For example at the handovers between shifts there was a safety handover which included a full history of people's daily intervention and the planned routine of people when known. Staff were aware of ligatures points within the home environment, and all staff were aware of where ligature cutters were placed. The registered manager explained that although the home was not a ligature free environment, thorough risk assessments for ligature points and other risks had been completed. Staff were informed how

to deal with such emergencies through training as well information in the daily handovers. There were four planned handovers a day, though more could be added where people's personal safety was compromised. Staff spoke at length about the counselling they undertake to support people who are experiencing suicidal ideas. Staff had access to a maintenance diary and were aware who to contact out of hours if an emergency arose, or an equipment repair was necessary.

We found the premises were adequately maintained to ensure the safety of people using the service. Personal emergency evacuation plans (PEEPs) had been completed and staff knew how to support people in the event of an emergency. Fire safety procedures and checks were also in place.

We saw that staff performed an annual infection control audit to ensure the risk of infection in the environment was minimised. Chemicals used in the home were assessed as safe and toxic free which were not harmful to people if accidentally swallowed. Staff had been trained in the control of substances hazardous to health (COSHH) and were aware how to handle chemicals safely.

We saw from records and staff confirmed that staff attended regular fire drills. A record of the staff who attended these events was kept which ensured the registered manager was confident that all the staff had adequate instruction on the procedures involved in ensuring people's safety in the event of a fire.

We found that staff were employed in sufficient numbers to provide support and guidance for people safely. One staff member said, "There is usually a ratio of one staff member to three residents, which is good."

We spoke with the registered manager who explained the staffing numbers were adjusted in line with people's dependencies, to ensure there was enough staff to continue to provide a safe environment for people. Staff confirmed the number of staff on duty each day. The registered manager was being assisted by the team leader and five recovery workers. We confirmed the staff numbers were typical with the current staffing rota.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff, and found that the relevant background checks had been completed before staff commenced work at the service. Staff we spoke with confirmed that they did not commence employment until they had the required pre-employments checks in place. This included a disclosure and barring check (DBS) and references. A DBS disclosure can help employers make safer employment decisions. Staff were recruited to match the cultural make-up of the local area.

We found that medicines were administered with people's safety in mind. One person we spoke with said, "Staff support with my medicines."

Most medicines were stored in people's bedrooms in a locked cabinet. People had been risk assessed to determine if they were safe to continue to control their own medicines. This resulted in some people having limited access to their medicines. Where restrictions had been placed on people, staff continually judged the risk, and adjusted the amount of medicines that people were provided with. For example, there were two people who had been provided with a two and four day supply of medicines. Staff also supported them with regular checks to ensure they had remembered to take their medicines at the correct time.

Other medicines in the office were stored securely and at a temperature to ensure they remained active. Staff kept records of the room and fridge temperatures, and were knowledgeable about what to do if they were above or below the recommended storage temperatures.

We looked at the medication administration records (MARs) for four people. Most of the MAR charts were signed appropriately, though there were some missing signatures. Some people who were prescribed 'as required' or PRN medicines had instructions along with the MAR charts which detailed what circumstances they should be administered and the maximum dose the person should receive in any 24 hour period. Staff understood the signs and symptoms that some people may display when they may require PRN to be offered. The staff records around PRN medicines, could be more detailed. Staff sometimes record these additional medicines on the back of the MAR chart which is the recognised method of recording, though sometimes not at all. This is inconsistent and could lead to an overuse of PRN medicines. The staff do not use photos on the MAR charts. From a security point of view, photo identification would enhance the safety around medicines administration and other areas of the care plan. Though as the registered manager pointed out people have a choice and staff could not insist on people giving consent to their photo being taken. Information about identified allergies and people's preference on how their medicine was offered was included. This helped to ensure that people received their medicines safely. We spoke with the registered manager who said changes to the medicines system would be considered

People were protected by the prevention and control of infection. Staff received training around people's safety, for example in food hygiene and infection control. There were policies and guidance for staff's reference. In addition, staff were supplied with Personal Protective Equipment (PPE) to protect people from the spread of infection or illness. Chemicals were placed in bathrooms, toilets and the kitchen to support people in maintaining a clean environment.

The registered manager stated any changes or outcomes from investigations would be documented and any lessons learnt fed back to staff. We saw from the minutes of staff meetings where outcomes were explained and staff prompted to ensure their practice was changed accordingly. The provider stated if necessary issues would be followed up at one to one meetings, to ensure people's confidentiality. Any development for the staff group would be in the form of a meeting as a team exercise, so all the staff could build on the learning experience.

Good

Is the service effective?

Our findings

People's needs and choices were assessed to provide effective care plans that guided staff to providing the correct levels of support that met people's cultural needs as well as their mental and physical health needs. The registered manager explained how people's needs were assessed prior to them moving into the home. This assessment then formed the basis of the care plan, which was developed and amended throughout the persons stay to reflect their changing needs. Staff completed WRAP plans, which fully captured the person's needs. We saw that care plans were updated regularly.

Staff were suitably experienced for their roles. A member of staff said, "We have detailed induction and on-going training as we work with people who have extensive and individual needs."

Staff commenced their training with an induction and then had access to courses, which directly related to their role within the staff team. The registered manager confirmed the staff induction training and on-going training were linked to the care certificate, which is a nationally recognised training course.

Staff told us that they had received an induction when they commenced work at the service and this included training and shadowing of more experienced staff. A staff member told us, "I shadowed [a permanent member of staff] until I was happy."

We saw evidence in the training matrix that all staff had updated training. The registered manager said the training matrix had been updated and would inform the management when staff training was required to be updated. We saw the registered manager had started to plan further training for the forthcoming year.

Staff confirmed that they had support through regular supervision meetings. Supervision is one way to develop consistent staff practice and ensure training is targeted to each member of staff. We spoke with the registered manager who showed us the record of staff supervisions that had been undertaken and the future planned dates. Part of the supervision included ensuring staff competencies, for example how staff administered medicines was overseen annually. All staff also an annual appraisal as part of the supervision regime.

People catered for themselves in the homes' purpose built kitchen. People were encouraged to shop for their own ingredients and continue to cater for themselves, so enabling them to continue a diet that met their cultural needs. There were 'back up' supplies of foodstuffs for anyone who was unable to go shopping for themselves in the short term. Staff monitored any food, which is past the recommended consumption date, and advised people about their personal food safety. It remains the responsibility of each individual if they wish to dispose of the food. This is due to people having capacity, to make their own individual decisions; the home offers support to people who require additional support, although promoting independence within the recovery process is the main aim. The registered manager said if people were considered to have additional nutrition needs they would be referred to the dietician or another suitable health worker.

Staff work together to deliver effective care and support. One member of staff said, "I feel rewarded by working at this home, we work as a good team." A second staff member said, "Staff work together as a team."

There was evidence that staff had access to a wide range of mental health professionals who worked together to achieve the best possible outcomes for people. We saw evidence that community psychiatric nurses and a consultant psychiatrist were regularly used to review people's care and treatment. Joint working with mental health community services is good practice to ensure peoples' mental health is closely monitored. This is designed to reduce the likelihood of relapse and re-admission to hospital.

The home had regular, effective and well-coordinated handovers. Staff held a handover meeting each morning, afternoon and evening to share information on service users, which discussed their progress and potential risks around the service user. Staff from the 'crisis unit' also attended all handovers, which provided all staff with information on all the people who lived at the home.

People had timely and responsive access to healthcare. We asked staff how people were supported to access health services. A member staff stated, "If there are signs or symptoms of a person not being well, I would of course contact the General Practitioner or in an emergency I would not hesitate to contact 999 paramedic services."

Staff promoted healthy living, and service users helped develop their own WRAP plans. As the home was considered a short term intervention, people were encouraged to retain their GP. We saw an example where a person was assisted to visit their GP, which was some distance from the home. This resulted in a medicine review for the person, and ensured they were on the proper medicine for their treatment and support at that time.

The building has been adapted to meet the needs of people where a block of flats was erected to house the 'crisis unit'. This gave people the support they required and improved their wellbeing. This also provided a quieter environment for people who might otherwise be distracted by the day to day disturbances in the main building.

All the people admitted to Trevayler had capacity. This was considered essential for them to fully engage with the WRAP plan and target their recovery to a specific time period.

The registered manager and recovery workers had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

There was no need for DoLS to be used at this location. The main gate to the drive was locked at 11.00pm and opened again at 7.00am; this was not used to restrict peoples' freedom, rather to ensure their security. People were free to have a key to the gate as well as a key to the front door of the building. Every person who lived at the home was offered a bedroom key, as well as locking facilities for their personal possessions, and where appropriate their medicines.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by a caring staff group. People we spoke with praised the staff and complimented the support and the calm environment. They described the staff as 'approachable, supportive and non-judgemental.' One person said, "Staff are brilliant here."

People told us the staff group were compassionate and caring. We observed interactions with people throughout the inspection which showed that staff were caring and people were treated respectfully.

One member of staff said, "We work hard to make this their home."

We also heard staff announce who they were [and the accompanying inspector] to a person who was resident in the 'crisis unit'. The staff member explained that although the person had met them before, there mental state could have resulted in them not remembering them or any previous conversation. That demonstrated a non-judgemental and compassionate approach by the member of staff.

We observed care staff had a good relationship with people and engaged in meaningful conversations. One person said, "The staff know me, I can chat with them when I need to."

The registered manager told us WRAP plans reflected people's needs and were reviewed regularly to ensure they were up to date. People confirmed they were involved in reviewing their WRAP plan throughout their stay.

We observed that staff were available to support people throughout the day. Individual choices, preferences and decisions made about people's care and support needs were recorded. Daily records included the care and support people received, and demonstrated that staff supported people's decisions about how they wanted to be supported.

People's privacy, dignity and independence were recognised and promoted. We observed staff respected people's privacy and dignity, and heard staff knocking on closed public area doors and people's bedrooms before entering. That demonstrated staff were aware of the need to ensure people's privacy and dignity. The registered manager said visitors were welcomed to the home, but were asked to leave prior to 10.00pm.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their individual support needs.

We looked at care files for three people, two who currently used the service and one who previously used the service. People's needs had been thoroughly assessed prior to them moving to the service. This information was gathered through, referral information, which included past, present and potential future associated risks with their current support needs.

The information gained from the assessment process was used to develop the care plan which also included a wellness recovery action plan (WRAP). This was to ensure that the person was at the centre of their recovery and through the WRAP was encouraged to take increasing control of achieving mental wellbeing. Staff were encouraged to access to a range of other recognised, evidence-based 'tools' to help them assess the person's support needs. An example of the many coping strategies and tools the staff had developed on an individual basis was a 'feelings pyramid'. This was used to identify the feelings people experienced, and grade them into those that were most intense. Other parts of the WRAP could include food, and people and places to avoid which would aid them by recognising a vulnerable area that could impede their recovery.

When we spoke with staff regarding people's support needs, they were able to tell us what these were and specifically for one person what specialist social support groups they were keen to engage with to aid their recovery. Staff were able to tell us what people's likes and dislikes were and mirrored what was recorded in the care and support plan.

People living at the home had a care and support plan, which set clear goals of what they wanted to achieve during their rehabilitation stay and encouraged people's independence where ever possible. Additional assistance and support was available if the person required this to achieve their identified goal. For example, providing written information for people to access community settings, college courses and training programmes.

The home was active in contacting commissioners and care coordinators to ensure the needs of people were adequately met particularly where they had developed additional support needs that required further intervention to enable, or following, their discharge back into the community.

The home had a full range of facilities to support a structured rehabilitation programme and meet peoples' needs and preferences. The layout and design of the home was a pleasant and peaceful homely environment that helped promote recovery, health and wellbeing.

On the day of the inspection, we reviewed people's care and support plans and found these contained structured goal setting with the people actively involved in the setting and reviewing of these. We saw these had been reviewed regularly and confirmed that peoples' changing needs were being supported and their physical and mental health needs were being addressed in a timely manner.

The registered manager looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider understood their responsibility to comply with the AIS and was able to access information regarding the service in different formats to meet people's diverse needs. Staff knew people well and knew how to communicate with them in a way they understood.

Visiting health professionals were involved in reviewing people's needs. For example on the first day of our inspection there were visits by a community psychiatric nurse and psychiatrist, who attended to undertake a review on person's WRAP.

Staff had access to people's care and support plans and received updates about their care needs through regular daily handover meetings. Staff told us a handover's took place, so staff could be updated about people's needs and if any changes in their care had been identified.

There was no specific activity co-ordinator employed within the staff group. The emphasis for the staff was that of support. For example the registered manager said staff would assist people to complete a shopping list and where necessary accompany them to purchase items to promote their independence. Further examples of this type of support included the garden project where people living at the home had arranged and painted parts of the garden furniture and stones. Another example was where people 'up cycled' articles purchased from second hand shops and items that had been donated, where these would be refreshed and be used when people moved back to their own accommodation.

The service user guide contained many other activities which staff could support people to do. These included learning to play musical instruments, access to laptops and tablet computers, a bicycle loan scheme and sports such as badminton..

There were also opportunities to become a member of an interviewing panel for new staff members or volunteering as a peer support worker. All of these helped towards an inclusive environment that aided independence and recovery.

People were supported to raise their concerns or complaints. People told us they were aware how to make a complaint, and the provider had a system in place to record and deal with complaints.

People felt they could approach staff with any concerns and were aware the registered manager and recovery workers were available for their support.

Staff felt they could raise concerns and issues with the registered manager and were confident these would be listened to and acted on. The registered manager told us there were not any complaints made to them in the last 12 months. They did say that any complaints that were made would be responded to in line with the providers' complaints policy and an outcome would be provided for each. Where necessary changes would be made to the service, and information fed back to staff through staff meetings or individual supervision sessions, so that staff were aware of any issues and any changes that had been required.

However, when we looked at the complaints policy, procedure and leaflet, none of these included details of the local authority, which is the appropriate body to investigate complaints. The registered manager said he would add the information to the complaints details displayed in the home.

We looked at the comments book in the 'crisis unit', which had been defaced but also contained some positive comments. A number of thank you cards were prominently displayed in the office in the main building they contained many positive comments.

The provider supported people to prepare for the end of their life. We saw that staff were enabled to plan changes to people's care, in advance for their end of life care. The provider had a policy to enable staff to intervene if required, that could be used in the final stages of a person's life, to assist them to have a dignified and pain free death. The registered manager spoke about one person in the past who required the staff's support to assist with a terminal illness, where the majority of staff support was for their emotional needs and accepting their diagnosis.

Good

Is the service well-led?

Our findings

Staff told us they felt there was an open culture amongst the staff team and the registered manager supported them well. We were told by one member of staff, "I know I can go to the manager whenever I want." Another member of staff told us that the registered manager was, "Supportive towards me," and "I feel that I am able to approach the manager."

The registered manager understood their responsibilities and displayed a commitment to providing quality care. Staff were aware of their accountability and responsibilities to support and protect people and knew how to access managerial support when required. Staff felt the registered manager was approachable and understanding, and told us they were supportive.

We spoke with the registered manager about the visions and values of the provider. They said there was an emphasis on openness and honesty throughout the home. They told us about the open agenda at staff meetings where staff could add items for discussion.

We found the provider's audit processes to monitor the quality of the service provided, were detailed and comprehensive, and ensured people received safe levels of care on a consistent basis.

The registered manager demonstrated the quality assurance audits that were regularly undertaken by staff within the home and the corresponding records which demonstrated people were safe and well supported. These included regular checks on the medicines system, care plans, risk assessments, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. These had resulted in follow up appointments being arranged for people at risk of malnutrition. That meant the registered manager and staff had undertaken audits that demonstrated how the service protected people.

The registered manager regularly oversaw staff activities and spoke with people and staff whilst in the home to ascertain how effective the staff group were. They said to us they also operated an 'open door' policy, where any person, visiting professional staff could speak with them at any time.

We asked the registered manager for the records of safety tests. The periodic test of gas and electrical appliances and water safety tests were all in date. Regular tests of the fire alarm system, emergency lighting were also in place and tested by staff on a weekly basis. That demonstrated the registered manager ensured the home was safe and demonstrated good management skills.

Staff were aware of the process for reporting faults and repairs, and had access to a list of on call contact telephone numbers if there was an interruption in the provision of service. Other information displayed in the office included instructions where the gas, electrical and water isolation points were located. Chemicals were not locked away as they were considered safe to leave in an open environment and were a non-toxic brand. That meant they were not harmful to people if accidently ingested.

Quality assurance questionnaires were sent out by the provider, and the results collated nationally. We

found people who lived in the home were approached before they left the home, and were asked if they were willing for staff to follow up their stay within 3-6 months of their discharge. This was done by a telephone call as not all people had a permanent address. However there was no on-going record of who had been contacted and the outcome of the call. The registered manager agreed to make a note of who had been called, when and what response was received if any.

The registered manager explained that some of the people who had been supported agreed to be mentors and volunteered to support people who currently lived in the home. They could choose to be placed on an accredited training and induction course or simply volunteer in the home. Dependant on their choice they could be paired with people who had similar experiences to their own. In the past some of these people had also been included on interview panels for potential new employees.

The registered manager said they would continue to have an open door policy and meet with people to gauge their opinions and ascertain the need for changes. The registered manager understood their responsibilities and ensured that we were notified of events that affected the people, staff and building.

The registered manager had a clear understanding of what they wanted to achieve for the people at the home and they were supported by the team leader and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

The registered manager was involved with managers from other locations in 'person in charge' audits. This was organised by the provider and encouraged managers to perform a check on each other's homes, based on the five CQC outcome areas.

The registered manager was also involved in 'best practice days', where along with other managers and senior staff, they would look at areas that had caused concerns. These regional meetings looked at challenges and better ways of working and problem solving as well as sharing good practice. Similar registered manager meetings involved people who had been supported with a stay in the home working together on co-production projects.

Staff were provided with detailed job descriptions and had regular supervision and staff meetings. The registered manager explained individual supervision was used to support staff to maintain and improve their performance. Staff confirmed they had attended supervision sessions and had access to copies of the provider's policies and procedures, which were updated regularly.

Prior to our inspection visit we contacted the local authority commissioners responsible for the care of people who used the service. They had positive comments about the registered manager, the staff and the quality of care provided.

One member of staff told us, "I would speak to the manager, he is very good, and you can approach him." A second staff member told us, "If I had concerns about another carer, the registered manager would deal with it."

Staff told us they felt there was an open culture amongst the staff team and the manager supported them well. We were told by one member of staff, "I know I can go to manager whenever I want."

Staff informed us, that there were regular staff meetings in place and they were encouraged to attend. One staff member said, "The manager is very good, when needing to organise things."