Huntercombe Homes (Ilkeston) Limited

Nottingham Neurodisability Service Hucknall - Millwood

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

We inspected the service on 16 and 17 November 2017. The inspection was unannounced. Nottingham Neuro Disability Service Hucknall is a rehabilitation and care home for adults with acquired brain injury and other complex neurological conditions. The service is provided over three units. 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. Nottingham Neuro Disability Service accommodates up to 71 people across the three units. On the day of our inspection 57 people were using the service.

At our previous inspection in November 2016 the service was rated as good. However we returned to inspect the service following concerns raised by the local authority related to the care of people who lived at the service. During our inspection we found the concerns raised by the local authority had been addressed by the provider and the service has retained a rating of 'Good.'

The service did not have a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left the service in September 2017 and the present service manager was in the process of applying to become registered with the CQC and completed the process following our inspection.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to protect them from harm and they lived in a clean, hygienic service.

People were supported by enough staff to ensure they received care and support when they needed it. Medicines were managed safely and people received their medicines as prescribed.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions and staff knew how to act if people did not have the capacity to make decisions to ensure their rights were respected.

People lived in a service which met their needs in relation to the premises and adaptions were made where needed. People had access to information in a format which met their needs.
People were supported to maintain their nutrition and staff monitored and responded to people's health conditions.

People were supported by staff who showed compassion and were empathetic towards them. They were supported to maintain their privacy dignity and independence.

People lived in a service that provided individualised care and staff had the information they required to provide that care. People were supported to follow their interests, take part in social activities and develop and maintain relationships that were important to them.

People were supported if they had complaints or concerns about their care and there was an open and transparent culture in the service where people were listened to and staff were valued.

The quality of the service people received was regularly monitored using robust quality auditing systems.

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.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

The risks to people's safety were regularly assessed and measures were in place to reduce risks and promote people's independence.

People were supported by adequate number of staff and received their medicines as prescribed. Medicines were managed safely across the service and staff administering medicines were provided with training to ensure they were safe to do so.

People lived in a clean and hygienic service and there were enough staff to provide care and support to people when they needed it.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision. People lived in a service which met their needs in relation to the premises and adaptions were made where needed. People had access to information in a format which met their needs.

People made decisions in relation to their care and support and where they needed support to make decisions, their rights were protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Good

The service was caring.

People were supported by staff who were empathic and showed a good knowledge of their preferences and choices.

People and their relatives were supported to be involved with the development of their care.

Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Good

The service was responsive.

People received individualised care and were supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Where appropriate people's end of life care wishes were discussed and plans of care were in place.

Is the service well-led?

Good

The service was well led.

There was an open and transparent culture in the service where people were listened to and staff were valued.

There was a comprehensive governance system in place to monitor the quality of the service.

Nottingham Neurodisability Service Hucknall - Millwood

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.

We inspected the service on 16 and 17 November 2017 and the inspection was unannounced. The inspection team consisted of three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved with the service and commissioners who fund the care for some people who use the service and due to the concerns raised by commissioners we brought forward our inspection.

During the visit we spoke with 11 people who used the service, four relatives, five care staff, one housekeeper, one cook, four nurses, two members of the therapy team, two unit managers, two members of the quality monitoring teams and the service manager. We also used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at all or part of the care records of nine people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service.

Good

Is the service safe?

Our findings

People and their relatives we spoke with across the three units had no concerns about their safety at the service. One person told us they felt safe and had not seen or experienced any abusive behaviour from the staff who cared for them. Another person told us they felt safe and staff looked after them well to keep it that way. Some relatives told us, "Yes we definitely feel [name] is safe here. We have seen no abusive behaviour. They (staff) all seem very caring. They went on to say that a member of staff would, and had, telephoned them if there was anything they were concerned about in relation to their loved one's care.

Staff we spoke with were aware of the different types of abuse people could be exposed to and had a good knowledge of what to look for in people's behaviour that might alert them to any issues of concern. They told us they had received training that helped them understand safeguarding issues and their role in managing any issues. The staff knew who they should report concerns to and were confident issues were addressed as they arose. One member of staff told us they had raised an issue of concern with their unit manager who had dealt with it professionally and the member of staff felt it had been satisfactorily resolved. All the staff we spoke with were able identify where the contact details of the local safeguarding team were should they need to use them.

The service used an incident reporting system for staff to report any incidents related to the care of people they supported. Staff had received training to use the system and incidents were reviewed on a daily basis at a multi-disciplinary meeting. Actions resulting from incidents were reviewed at the meeting and discussions were held on who would communicate outcomes and any changes in practice to the staff team.

During our inspection we witnessed a discussion regarding a security issue that staff had reported. The actions the Quality & Nursing Lead for the service had taken to resolve the issue were fed back to the multi-disciplinary team for them to relay to their teams. This showed how the systems in place at the service worked to protect the people in their care.

The information related to people's safety we received from the service had been improved over the months prior to this inspection. The service manager told us they had worked hard with unit managers and senior staff to ensure they understood the importance of reporting any issues that may be considered a safeguarding issue. As a result both we, and the local safeguarding adults' team, had been given information about issues that had occurred and action taken to reduce the risk of reoccurrence.

People could be assured safe recruitment practices were followed. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

People told us they had the equipment they needed to support them and reduce the risks arising from the

different aspects of their care and support. For example two people told us they each had a specially adapted wheelchair to allow them to move around the service safely, an adjustable bed with a special mattress to prevent tissue damage, and when they were in their rooms they had access to a call buzzer. Another person told us they had a lap belt in place when they were in their wheelchair. The person told us the reasons for the lap belt had been explained to them and they had consented to its use.

Risks to people were assessed and evidenced in their care plans. Staff had access to information about how to manage the risks. A number of people required bed sides to prevent them from falling out of bed, we saw the risk assessments had established this was the most appropriate way of keeping these individuals safe. Where appropriate people had consented to the use of the rails.

Some people who used the service had swallowing difficulties and required enteral feeding methods. One method of this type of enteral feeding is where a tube is inserted directly into the person's digestive tract. This is to allow them to receive sufficient nutrition without the need to swallow food. Where people required this method of nutrition their care plans showed the rationale for this and provided guidance for staff on how to manage care and support in this area.

People were living in a safe, well maintained environment and there were systems in place to minimise risks. We saw there were systems to assess and ensure the safety of the service in areas such as fire and legionella and control measures were in place to reduce risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were risk assessments related to the risks people faced if they needed to evacuate the building in an emergency.

People told us they received the care and support they needed in a timely way. One person told us, "Yes I think so, even at weekends and at night." Another person said, "Yes quick response." Relatives said they felt their relations were supported by sufficient numbers of staff. One relative said, "[Name] has one to one care each day, so they are never left alone whilst awake and staff check [name] when asleep." We observed there were sufficient numbers of staff to meet the needs of people who used the service and staff were available to provide support when people needed it. Staff told us they felt there was enough staff rostered on duty to meet people's needs. One member of staff said, "Even if we are a member of staff short we will work round it." Another member of staff said, "This is the only place I have worked where the staffing is good." They told us if there was short notice sickness the unit manager would try to find a replacement or book agency staff.

We spoke to the management team who told us, whilst they sometimes needed to use agency staff, they used particular agencies and tried to block book staff so they were confident shifts were covered with agency staff who were known to the service. The service manager explained that all agency staff received an induction pack and support before working at the service.

People with expressed no concerns in the way their medicines were managed for them. One person told us the staff would give them their medicines and ensure there was a glass of water to help them swallow any tablets. They said they received their medicines on time. Relatives were also happy with the way their loved ones were supported with their medicines. Staff told us they had received appropriate training and support to safely administer medicines. One member of staff told us as well as the training they received, senior staff also undertook regular competencies assessments with staff to ensure on-going safe practice.

During our inspection we looked at medicines management on all three units and found the practices on each unit were safe. There were regular checks on the storage of medicines and where we found some minor issues in relation to daily checks on one unit when we discuss this with the unit manager we found they had already identified the issue and were addressing it. Each unit undertook a weekly medicines audit

and sent the results to the Quality Assurance Manager who analysed the audits and fed back to the units on any issues or trends that needed addressing.

People told us the service was kept clean and staff always washed their hands before providing care for them. One person said, "(The) service is clean and staff clean my bedroom." Staff understood their roles in minimising the possible spread of infection.

During our inspection we observed one instance that could have placed the person at risk of infection. We discussed this with both the staff and the service manager. Both of whom recognised the issues raised and assured us they would address the issues we raised. Following our inspection the service manager sent us information to show how they had addressed the issue. They had arranged for refresher training for staff who undertook these interventions and had implemented an updated protocol using based upon current good practice. This had been circulated to all units to ensure all staff and unit managers had the information they needed to deliver a good standard of care moving forward.

We discussed the cleaning schedules with a member of the housekeeping team who told us there were enough staff to maintain a clean environment. They told us the management team undertook regular audits of the environment and fed back if there were any issues of concern. Staff told us they had received appropriate training in areas such as safe food handling and hand washing. Staff had access to policies and procedures on infection control that met current national guidance and had a good understanding of why systems for managing the risk of the spread of infection were important.

Good

Is the service effective?

Our findings

.The treatment and care people received at the service was delivered in line with current legislation, standards and evidence based guidance. The care plans we viewed that gave staff information about particular aspects of care showed appropriate guidance tools had been used. There were examples of how the different nationally recognised tools were used for all aspects of people's care. One member of staff was able to show us the how they had used nationally recognised guidance from organisations such as The National institute of Clinical Excellence (NICE) for the use of enteral feeding. We also saw a number of other nationally recognised assessment tools such as the Braden scale, which is an established tool developed to assess a person's risk of developing a pressure ulcer, was used to develop an appropriate plan of care for a person who had developed a pressure ulcer. The service also used the Malnutrition Universal Screening Tool (MUST) to assess and effectively manage people nutritional needs.

People's needs around accessing information had been considered. People living in the service had varying levels of ability to verbally communicate and to understand written documents. The service had ensured that all people had access to information that enabled them to understand their care needs and the health services available to them and this ensured people were not unduly discriminated against. Information about people's rights was displayed on a notice board for people using the service in an easy read format. Some people used a computerised tablet and speaker to communicate with their relatives and staff. Majority of staff had undertaken equality and diversity training and the service manager told us they had plans to ensure all staff undertook the training in the near future.

The assessment of people's diverse needs was embedded in the service to ensure there was no discrimination, including in relation to protected characteristics under the Equality Act. The staff we spoke with and the care plans we viewed showed these characteristics had been considered when providing care for people. For example, ensuring people's received their preferred diet in relation to their faith or ensuring their care was planned around their worship routine.

People were supported by staff who were trained to support them safely. The relatives told us they felt the staff knew what they were doing. One person told us, "I know staff go on training, they are gentle with me. They know me now." Another person said, "The care is ok I would give it 10 out of 10." A further person told us the service's occupational therapist had recently trained a group of staff on a new piece of equipment. We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately.

Staff were given an induction when they first started working in the service. One member of staff told us they had been able to shadow another member of staff for a week following their induction. This had allowed them to spend time looking at people's care plans and familiarise themselves with the names of people using the service and their care needs. Staff told us they had been given the training they needed to ensure they knew how to do their job safely and to support people who used the service appropriately. They told us if they felt they needed any additional training the service manager was responsive to this. Some staff were able to give examples of the extra training they had received. A nurse said they had been given the

opportunity to refresh their clinical skills. They gave an example of undertaking catheterisation training to refresh and update their skills. Another nurse told us they had undertaken an accredited three day course in tracheostomy management that allowed them to support other nurses at the service. They also told us three other nurses had attended the National Tracheostomy Safety Project (NTSP), which was a nationally recognised course, to improve the skills and knowledge base at the service. Another member of staff explained how all staff were undertaking training in conflict management, conflict resolution, physical intervention and restraint reduction, to help them manage challenging behaviours and improve outcomes for people and staff in these situations.

Staff were also supported with regular supervisions and one of the unit managers told us staff had started to ask for supervisions as they recognised the value of it. This showed the service was continuing to work to ensure staff were supported with training appropriate to their roles.

People's nutritional needs were well managed and people spoke positively about the food choices available to them with comments such as "Good variety." One person said, "Yes a lot (of choice) breakfast, lunch, tea and supper." Another person told us there were regular snacks and drinks available to them. One person told us they were able to feed themselves via a tube sited directly into their stomach. They said they had staff back up and all their equipment conveniently situated for use and well maintained by staff.

Staff showed a good understanding of people's nutritional needs. There was a resident Speech and Language Therapist (SALT) employed by the service who assessed people who had swallowing difficulties and there was good communication on between the SALT and the kitchen staff. The cook showed us how the information on people's dietary needs was managed. They had a file in which they kept the information from people's SALT assessments and they went out to talk to any new person admitted to the service to understand their dietary preferences. The cook also monitored the food ordered by staff for people to ensure it was appropriate for the individual and fed back any areas of concern. People's weights were monitored to ensure they maintained a healthy weight. Any issues were responded to quickly. For example at the morning meeting we attended, it was raised that one person who had recently commenced an enteral feeding regime had gained weight over a very short space of time. This discussion resulted in the person being immediately referred to the dietician to adjust their enteral feeding regime.

People at the service benefited from the multidisciplinary team working on site. The morning operational meeting held each day had representatives from each unit, the quality assurance manager and members of the service's therapy team. This ensured that as issues were raised they were addressed by the most appropriate health professional. The therapy team on site consisted of a clinical psychologist, speech and language therapy team, physiotherapy team and occupational therapy team. This team had recently moved into one office to improve communication with each other and, as well as attending the daily catch up meeting, held multi-disciplinary meetings with people to discuss the care individuals required. We saw a number of examples of the positive input from the therapy team in people's care. For example, a person's care plan for positioning was put in place with the input of an occupational therapist. The physiotherapist gave an example of how they had changed a person's treatment and amended the person's care plan so staff were aware straightaway of the updated treatment routine for the person. Staff told us there had been improved communication with the therapy team and this had a positive impact on the care people received.

People were supported with their day to day healthcare. One person's relative told us their relation had suffered an acute infection. They told us the GP had visited and prescribed medicine and the infection had cleared up. They also told us the person had access to the optician and the staff escorted the person to the dentist when this was required. When health professionals were due to visit this was raised at the morning

operational meeting so all staff were aware. For example, on the first day of our visit it was noted the dietician was visiting the service to see six people across the units. This was fed back to the relevant staff so they could ensure that people knew and the necessary records would be available for the health professional. The service manager explained the service was supported by three GP's and staff sought advice from external professionals when people's health and support needs changed and followed recommendations made. We saw evidence in people's care plans of these recommendations and staff demonstrated knowledge of people's health needs.

People lived in a service which met their needs in relation to the premises. The service was split over three units and two floors. There were a number of communal areas for people to use as well as being able to have private time in their own rooms. Consideration was given to making sure people were in the most appropriate room for their needs. For example, some room changes were discussed so one person would be nearer the nurses station as they required closer monitoring and another person who was a wheelchair user was moving into a vacant room which was a little bigger gave them greater manoeuvrability.

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.

The service was working within the principles of the MCA, people we spoke with were happy that staff discussed any care before providing it. A relative told us, "Staff always explain what they are doing." Staff understood their responsibilities in relation to the MCA when supporting people who may need help to make decisions.

We viewed a number of records, where people had been assessed as lacking mental capacity, best interest decisions had been recorded to ensure the care they received was the least restrictive and in the best interests of the person. These decisions had been taken with the support of the appropriate health professionals and where appropriate the person's family. One senior member of staff explained the process they had gone through to support one person with complex needs who required support with their treatment. The member of staff had worked with the person and a range of health professionals involved in the person's care to formulate a best interest's decision. It was clear from the conversation the member of staff had an in-depth knowledge of the MCA and had worked to ensure the person received support and the most appropriate treatment for their care whilst working in their best interests.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The service manager had made applications for DoLS where appropriate. For example, one person who had a DoLS in place for the use of bed rails and lap belt. The rationale for the decision and the way the person should be supported was clear in the records we viewed.

Good

Is the service caring?

Our findings

People we spoke with were happy with the care they received from the staff who cared for them. One person said, "(Staff) kind yes and caring. "Another person put their thumb up and said, "Good" in answer to our question of whether they were happy living at the service. Their relative told us, "[Name] is happy here, they get plenty of visitors and the staff are very friendly. The staff and cleaners drop in to see them."

Staff talked about people they cared for with empathy. One member of staff told us there was a positive culture at the service, they said, "Staff speak to people as equals." The staff were knowledgeable about the needs and preferences of the people they cared for. We saw a number of positive interactions between staff and people who lived at the service. There was a wide range staff caring for people at the service and we noted that all staff were familiar with people and took the time to engage with them throughout their shifts.

Where people had expressed a preference for a particular gender of staff we saw this had been respected. One family we spoke with told us their relation only had female care staff and the person was happy with that. Another relative told us their relation did get a little embarrassed at having a different gender of staff assist them with their personal care, although when we checked their care plan this had not been raised as an issue. We discussed this with the service manager who told us they would address this with the person and the staff who cared for them to ensure their wishes were supported.

People had the opportunity to express their views and make their own decisions about their care. Where people were unable to verbalise their views there was provision in place to support them. We saw a number of people had assistive technology to enable them make their needs known to staff. One relative told us their loved one used an electronic tablet to communicate with staff. One person indicated to us they were involved in planning their care, their relative also confirmed they had also been involved. Another relative we spoke with was very knowledgeable about their relation's care planning and told us they had been involved in two or three reviews during the past five months. The care plans we viewed contained evidence of people's involvement in the development and review of their care plans. A member of staff told us they regularly discussed people's needs with both the person or their relatives if appropriate and told us people were given a copy of their care plans. They commented, "We talk about what is important to them, some people will definitely tell us if things aren't right." The member of staff felt this was how it should be.

We discussed one person with a staff member who told us they had worked with the person to develop their plan of care. They discussed how important it had been for the person to have some sense of control over their care. They told us the person wished to manage their own hospital appointments with their relative and inform staff of any outcomes.

The care plans also contained good information about how to communicate with individuals, for example one person's care plan included what caused upset to the person and how to provide reassurance for them. One member of staff told us how they supported one person who sometimes struggled to verbalise what they wanted to say. The staff member told us that they needed to give the person time and encourage them to take time when talking. It was clear the member of staff had a good knowledge of and worked with the

person to ensure they were able to communicate their needs in the best way they could.

People had access to the services of a lay advocate. An advocate is an independent person who supports empowers and speaks up on behalf of people who may not otherwise have a voice. The advocate came into the service each week and visited each unit to chat to people and ensure they knew the support of an independent advocate was available to them. We also saw information on notice boards around the service on the availability of the advocate. The Advocate chaired regular resident and relatives meetings so people's views on their care at the service were heard.

People told us staff who cared for them respected their privacy and treated them with dignity and respect. People told us staff knocked on their doors before entering and were respectful when providing personal care. Staff showed a good understanding of their responsibilities in assisting people to maintain their privacy and dignity. Throughout the visit we saw staff managing people's needs in a dignified way. The service had information for people, relatives and staff on notice boards near communal areas about the importance of maintaining people's dignity.

People were supported to be as independent as they could be. One person told us they were able to transfer themselves in and out of bed, dress themselves and manage to feed themselves. They told us they used their wheelchair to move around the service and that staff only supported them when they needed them. Staff told us they always tried to encourage people's independence and worked with the therapy team so the approach to people's promoting people's independence was coordinated . They said they would stand back and let people do what they were able and then offer support. People's care plans contained information for staff about how much the person could do for themselves and where they required assistance to ensure staff encouraged people to be as independent as possible.

Good

Is the service responsive?

Our findings

People's preferences for how they were supported was discussed with them and their significant others to ensure people received personalised care in the way they would like. People told us they were happy with the way they received their care, relatives we spoke with supported this. One relative said, "The carers know [name] well and know their likes and dislikes." Another relative, whose relation received one to one care, told us there were some experienced staff who supported their relation well and were kind and caring towards them.

Staff told us the information they required to support people was in their care plans. One member of staff told us they got to know people by reading their care plans which recorded their likes and dislikes. They went on to say assessments were carried out before a person was admitted to the service so care plans could be formulated for the person. Staff also received regular updates in shift handover, and members of the therapy team who supported people's care told us they contributed to people's care plans when they were providing treatments or therapies for them.

The care plans we viewed were reflective of the care individuals required. They demonstrated a careful consideration of the person's individual needs and were updated to reflect changes in their needs. Care plans for the management of people's health conditions were generally detailed and reflected their current needs. For example, a person's care plan for the management of a significant medical condition contained personalised information about indicators the person's health condition was becoming unstable. The plan contained details of action staff should take during this period and when they needed to intervene with particular treatments and rescue medicines.

We also viewed a person's care plan for the management of an enteral nutrition tube, which gave information about the type and size of tube and the paper records in their room provided details of the feeding regime and care of the skin site, but there was no information about what staff should do if the tube came out/was removed. We mentioned this to the unit manager who rectified this.

People's cultural needs were considered as part of their care. People who required support to practice their faith were provided with this support. For example one person's care plan showed they required a safe and quiet area to pray, provision of fresh water and it also recorded their religious routines and what support the person received from their family for this aspect of their care.

People were supported to follow their interests, take part in social activities and develop and maintain relationships that were important to them. Some people told us they enjoyed watching T.V, baking, art work, bowls and going out to see films. One person told us they were able to play netball, boxing and the service had a good gym. The person said they were able to go out walking. One relative told us the staff had arranged a birthday party for their loved one, they said "staff spoil [name]." People told us they had been able to develop friendships with other people at the service. One person told us they got on with the person who lived in a room adjacent to them and they sat with this and another person at meal times which made

the event more sociable for them.
Other people told us how they were supported to visit family and friends and take part in social activities with them such as family outings to the pub.

The activities co-ordinator told us there were three activities co-ordinators at the service. There was a weekly programme of events and the activities co-ordinators were introducing new things onto this programme, such as, preparing a cooked breakfast to improve cooking skills. The activities coordinator supported a small number of people who wished to attend church coffee mornings and also undertook trips three times a week so people could go shopping or go out for coffee. The member of staff told us they ran art and craft sessions, baking and sewing sessions, they also undertook one to one sessions with people who spent time in their rooms. The service manager told us the team worked hard to provide the people with the social activities that were important to them, and was also able to give us examples of how they had provided particular events or activities for people at significant times in their lives such as birthdays.

People and their relatives knew what to do if they had any concerns or complaints about the service. They saw the unit managers as their point of contact if they wanted to raise concerns or complaints and also felt they could raise issues with staff. One person said, "Always sort out issues with staff, social worker, advocate or manager." One relative gave us an example of a complaint that they had raised with the unit manager and how the issues had been resolved to their satisfaction. Another relative told us they had raised an issue of lack of cutlery on the unit where their relation lived. The manager had responded quickly and the amount of cutlery had been increased to address the issue. People and their relatives told us they had seen information on notice boards about how to make a complaint and we saw these posters were in communal areas throughout the service with easy read formats on display.

Staff were aware of their roles in managing complaints so positive outcomes could be reached for people. One member of staff told us they would try to resolve small issues, but if they could not they would report concerns and complaints to the person in charge at the time. They told us they would record their actions and they had confidence in the unit manager to deal with any complaints raised to them. Our discussions with the unit managers and service manager and the records we viewed showed they understood and managed concerns and complaints in line with their company's policy.

Where appropriate people's end of life wishes had been discussed with them or their relatives and advanced care plans for some people were in place. Staff told us they had been supported with training so they had the knowledge and skills to give people and their families the necessary support they needed. One member of staff told us they had undertaken an accredited course that they had found very useful and within the team there was a range of skills to ensure people were supported both emotionally and physically to have a peaceful death when the time arose.

Good

Is the service well-led?

Our findings

At the time of our inspection there was not a registered manager in place, however there was a service manager who had applied for their registration with the CQC. Following our inspection the service manager completed the process and became the registered manager for the service. We found the service manager was clear about their responsibilities and they had notified us of significant events in the service and the last CQC inspection rating was displayed in the service. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home and on their website.

Each unit had a unit manager and people we spoke with told us they were more familiar with these individuals and had confidence in them. Some people at the service also knew the service manager by name, and we received positive comments from all of the people we spoke with about the managers at the service. People and relatives told us they were a visible and approachable presence in the service.

Staff had confidence in the management teams and felt recent introductions of initiatives had improved the service. One member of staff said, "We all try our best, we all come together and work as a team." Another staff of staff said, "I want to stay here, the team work is really good." A further member of staff told us there was, "a positive energy," in their unit. Staff felt there was more structure, they were able to raise issues of concern in an open way and the issues would be dealt with to improve the service. A unit manager said the culture amongst staff was changing. Previously staff had not brought issue to them and did not tell them about day to day problems and "made do" now they were starting to bring things forward as they realised the issues would be addressed.

We saw a further example of how the service was empowering their staff to speak up and give their opinions on the systems and processes at the service. A member of staff who had been supporting a new member of staff through the induction process raised some queries about the new induction process with the service manager at the regular morning meeting. They discussed the queries briefly and the service manager arranged to have a further discussion with the member of staff and raise their queries with the team who had developed the induction programme.

All incidents and accidents were discussed at the daily handover meeting to ensure they were addressed openly, so staff could learn from actions taken following these incidents, and feedback any changes to practice or share good practice with their teams. For example, an incident involving a member of agency staff was raised. Discussion took place on whether it was appropriate for the service to support agency staff with a particular type of training the service was providing for their own staff, and how this could be arranged.

The service had a comprehensive governance framework in place to monitor performance for the different aspects of care provided. The process was managed and overseen by the Quality and Nursing Lead for the

service. The service had undertaken a review of the quality monitoring process at the service in the previous few months and as a result had employed the Quality and Nursing Lead. This member of staff was managing the electronic incident reporting system at the service. They ensured all actions from incidents were followed up so information could be used to improve the quality of the service, The Quality and Nursing Lead also analysed the data from the different audits undertaken by the unit managers and staff at the service. Such as medicines, care plans, environment and infection control. They then feedback any issues to the unit managers for any necessary actions, they also chaired a monthly governance meeting to discuss any trends and ensure the auditing processes in place were effective.

The Quality and Nursing Lead was being supported by the company's Quality Assurance Partners who worked across the organisation to support the services within the company. The team conducted independent audits of the service. This allowed the company to review the audit processes to ensure they are robust and standardised. The Quality Assurance Partners also provided a monthly analysis and report on all falls, incidents and accidents at the service to establish any trends so appropriate measures could be taken. The unit managers felt the auditing processes at the service were meaningful and they were able to monitor and improve practice as a result of the robust systems in place.

The majority of people, relatives and staff we spoke with told us they were listened to and were engaged in the development of the service. People told us there were meetings that were chaired by the advocate who visited the service, one or two people told us they did not attend the meetings by choice. Other people told us they were able to discuss their points of view at the meetings.

The service manager told us of a number of initiatives in place to involve people in the running of the service. The company has a suggestion box which was collated monthly and a 'you said we did' and a feedback sheet produced to show people how the service had acted on suggestions made. Some people were involved in choosing colour schemes for the redecoration of parts of the service. Other people had been involved in staff interviews formulating their own questions and being on the interview panel for prospective staff. The service manager believed people living at the service should have a say in who supports them with their care and told us these initiatives had been a big boost to the people involved.