Voyage 1 Limited

Tudor Rose

Inspection report

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Date of inspection visit:
18 February 2016

Date of publication:
12 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 18 February 2016 and was unannounced. Tudor Rose is a care home registered to provide accommodation and personal care for four adults with a learning disability. At the time of our inspection there were four people living at Tudor Rose. The home is located close to the town of Alton. People were accommodated in single bedrooms. At the time of our inspection building works were being carried out to improve the facilities in the home by adding en-suite bathrooms, a staff sleep over room, and improvements to the garden and communal areas. An additional bedroom was being added as the provider planned to increase the occupancy of the home to five people.

The service had a registered manager. However, the registered manager had been absent from the service since 13 November 2015 due to unforeseen circumstances. 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. An interim manager was in place to cover the absence of the registered manager.

People's relatives told us people were cared for safely at all times. Staff had completed training in safeguarding people from abuse and records showed any concerns raised were acted on appropriately. Details about how staff, people and others could report any concerns about people's safety directly to the provider were displayed in the home.

Staff knew about the risks to people's safety and wellbeing and these were recorded in their care plans. Risk management plans provided guidance for staff on supporting people safely and minimising risks to them and others. Information was available to staff and others as required to support people in an emergency situation. Some of this information required updating and the manager assured us this would be completed without delay. People practised fire drills so they knew how to act in the event of an emergency evacuation due to a fire.

Sufficient staff were deployed to meet people's needs and care for them safely. When agency staff were used they completed an induction into the home and people's needs. Wherever possible the same agency staff were used. This provided a consistency of care for people. Staff were recruited safely. The provider carried out the required pre-employment checks to protect people from the employment of unsuitable staff.

People's medicines were managed safely. Staff were trained and assessed as competent to administer people's medicines.

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 Mental Capacity Act (2005). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

DoLS Applications for all people living at Tudor Rose had been made in October 2014. The outcome of these was not evident in the care plans we reviewed. A mental capacity assessment and best interest decision making process had not been followed prior to the submission of the DoLS applications. This meant there was a lack of written evidence as required to demonstrate how the decision to submit DoLS applications for people had been made and whether the applications made had been authorised.

Staff completed an induction into their role and completed training to enable them to meet people's needs. All staff were trained to use Makaton which is a language programme using signs and symbols to help people to communicate. This meant people were supported by staff who could use their preferred method of communication.

People were supported to maintain good nutrition. People's needs in relation to nutrition were assessed and monitored to identify any additional support required. People chose the food they ate and were supported to maintain a healthy and balanced diet.

Staff acted promptly to ensure people's healthcare needs were met. People records included information about their healthcare appointments and any follow up treatment required. People were supported to maintain their health.

There was good continuity of staff who had been in post for some time. This meant people had established relationships with staff who knew them well. People's relatives told us this was important and that the staff were caring in their approach to people, enabling them to build positive relationships.

The provider and staff were committed to ensuring any new person coming into the home would be compatible with the existing residents people and share their communication methods. This meant people's needs were considered and respected.

People were supported by staff who knew their interests and preferences. Staff were aware of how people preferred to be supported if they became distressed and spoke about people with warmth and compassion. People were supported to communicate their views, decisions and feelings. People were treated with dignity and respect and enabled to enjoy private relationships with friends and family.

People were supported to engage in a range of activities to meet their needs and interests. People enjoyed doing activities together and when they preferred to do different activities this was accommodated.

People's care plans were person-centred and included information about their needs, preferences and abilities. Monthly meetings with their keyworkers enabled people to be involved in the review and planning of their care. Where people's needs changed these were updated on their care plans so they continued to receive appropriate care.

Staff acted promptly to ensure where people's need changed they received the appropriate support. This included support from other professionals to assess people's needs and provide guidance for staff on how

to support people effectively. This helped people to maintain and improve their quality of life.

A complaints procedure was in place and available to people in an accessible format, such as easy read and pictorial. No complaints had been received, however people's relatives told us they were able to raise concerns and these were responded to.

The provider had ensured adequate management support was in place for people and staff in the absence of the registered manager. Staff spoke positively about managers and team work in the home. Relatives told us the home had an 'open' culture and the registered manager responded to their feedback and concerns. Some relatives felt communication had fallen short over the proposed building works and occupancy changes. This had been responded to by the provider.

Staff demonstrated the provider's values in their work with people and managers worked alongside staff to monitor this in practice. People and their relatives were asked for their feedback on the service and this was acted on. A quality assurance system was in place to drive continuous improvement to the service people received.

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 protected from the risk of abuse, because staff understood how to identify, report and address safeguarding concerns. Concerns about people's safety were acted on.

Risks affecting people and others were managed safely through a process of assessment and risk management.

There were enough staff to meet people's needs. Recruitment processes in use protected people from the employment of unsuitable staff.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective

It was not clear whether an authorised deprivation of liberty safeguard (DoLS) was required or in place to ensure peoples rights were protected. It was not evident whether applications made to deprive people of their liberty had been authorised. Applications had not been underpinned by the relevant assessments of people's mental capacity to agree to the conditions of their care and treatment.

People were supported by staff who had completed training to meet people's individual needs and to carry out their role effectively.

People's dietary needs and preferences were met. People were supported to maintain their health and access healthcare as required.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and

understood their needs and interests.

People were treated with kindness and respect by caring staff.

People's rights to privacy, dignity and choice were respected by staff.

Is the service responsive?

Good

The service was responsive

People were supported to participate in activities to meet their interests and needs.

People received person-centred care that was focused on their individual needs and goals.

Procedures were in place to enable people to complain if necessary in a format that met their communication needs.

Is the service well-led?

Good

The service was well-led

The provider had ensured adequate management support was in place for people and staff in the absence of the registered manager.

People were supported by staff who acted in line with the provider's values.

Staff were supported by managers to know and understand what was expected of them in their role.

Quality assurance processes were in place to monitor and assess the quality of care people received and to drive service improvements.

Tudor Rose

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 took place on the 18 February and was unannounced. The inspection was carried out by one adult social care inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We did not request a Provider Information Return (PIR) before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

People were out of the home during parts of our inspection and some people were unable to tell us in detail about their experience of the care they received. We observed the care and support people received as much as possible throughout our inspection to inform us about people's experiences of the home. We spoke with one person living at Tudor Rose and two people's relatives to gain their views of people's care. We spoke with the interim manager, the operations director, and two support workers. We spoke with the registered manager who visited the service during our inspection. In this report we have referred to either the registered manager or manager. The manager is the person who is currently responsible for the day to day management of the service in the absence of the registered manager.

We reviewed two people's care plans, including their daily care records, and medicines administration records (MARs) for four people. We looked at two staff recruitment and supervision files, and the staff roster from 21 December 2015 to 31 January 2016. We reviewed policies, procedures and records relating to the management of the service, including quality assurance audits, minutes of meetings and emergency procedures.

We have not previously inspected this service.

Good

Our findings

People were cared for safely. A person's relative said the service was"100% safe" and another relative said "I have no concerns about safety, always 24 hour care and they (people) are always supervised when out and about". People's relatives told us this level of support was important to ensure people were safe at home and when out in the community.

Staff had completed training in safeguarding people from abuse. Information and guidance was available to staff in the home to guide them on the actions to take if they had concerns. A staff member told us the provider had a 'hotline' for reporting concerns. This was an initiative called 'see something, say something'. A poster was displayed in the service with contact details for people, visitors or staff to call, write, and text or e-mail information of concern. A staff member said "If I had concerns I would speak to manager or above and record and report. People have the capacity to tell us and we have 'see something, say something'". Records showed safeguarding concerns had been dealt with appropriately. People were supported by staff who knew how to report concerns and these were acted on to keep people safe.

Risks to people were assessed based on their individual needs. People's support guidelines included a risk rating to alert staff to the severity of the potential risk and the actions required to minimise the risk to people and others. These included risks to people's health, risk of vulnerability from others, for example, from exploitation and financial abuse, and risks from behaviours that may challenge others. Risk management plans were detailed and included information about what was important 'to' the person and 'for' the person in managing the risk. Staff understood people's safety needs and told us about the support they provided to people when required. This was consistent with people's risk management plans. This meant staff knew how to take appropriate action to minimise risks to people they supported and others.

Information to support people in the event of an emergency was available to staff and others as required. This was held in two 'grab' folders, one in the office and one by the front door. Information included; peoples personal emergency evacuation plans (PEEP's) their medicines, identity information, hospital passports and communication passports. Hospital and communication passports contain important information about people to guide others on their needs should this be required in an emergency situation or a hospital admission. People were involved in regular fire drills to support them to know how to act in the event of a fire. The registered manager said "We used a picture of a fake fire to help people learn where they needed to go and they are really good at working it out". Procedures were in place to minimise the risk of harm to people in an emergency.

People were supported by two staff during the day and one staff sleeping in overnight. The manager was additional to support staff but occasionally worked support shifts when other staff were not available. One person had additional support hours during the day. The additional hours were under regular review by the commissioner so the provider was unable to recruit to this post on a permanent basis. This meant cover for these hours was supplied by existing staff, the provider's bank staff or agency staff. A staff member said "I do think there is enough staff we have one to one support funded for a person which has put an additional strain on staff here. Because we can't always get it covered we have to use agency but that's the only issue". We reviewed the staffing rotas for the period 21 December 2015 to 31 January 2016. These records showed staffing arrangements were as described. We observed people were responded to promptly by staff during our inspection. There were sufficient staff deployed to meet people's needs and support people safely.

The manager told us they did not use agency staff for overnight cover. Records showed agency staff completed an induction into the home that included; people's care plans, grab files, health and safety procedures and aims of the service. Wherever possible familiar and regular temporary staff were used to provide a continuity of care.

Records showed the provider completed the required recruitment checks for new staff. This included; proof of identity, a criminal record check, a full employment history including a written explanation of gaps in employment and references from previous employers. This meant people were protected from the employment of unsuitable staff.

Procedures were in place for the ordering, storage, disposal and recording of medicines and these were followed. Staff completed training in the administration of medicines and were assessed as competent to do so by the manager prior to carrying this out. Training was repeated every two years and an annual competency check was completed to ensure staff continued to be competent to administer medicines safely.

People's medicine administration record (MAR) included a photo of the person. A photo provides an identity check for staff when administering medicines to ensure they are given to the right person. One person self-administered a medicine and kept their own record of this, which was checked by staff. When people were prescribed medicines to be taken as required (PRN), guidelines were in place to inform staff when and how this medicine was to be used. People's medicines were managed safely.

Requires Improvement

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that some decisions about people's care and treatment had been made following the appropriate procedures under the MCA. For example; a person had documented assessments and decisions relating to; the use of a coded keypad on the front door, management of their finances, and involvement in their care planning and visiting their parents. This evidenced an appropriate process had been followed to ensure the person's rights were upheld in decisions made about their care and treatment.

Applications for a DoLS had been made on behalf of all people living at Tudor Rose. These had been submitted in October 2014 by the previous registered manager. However, the outcome of these applications was not evident in the care plans we reviewed. Managers were not clear about whether the applications had been authorised or not. A DoLS application is required to protect the rights of people who lack the mental capacity to agree to their care and treatment and any restrictions in place. Restrictions were in place such as a coded keypad to the front door and a locked side gate and people required staff support at all times when out in the community. A mental capacity assessment and best interest decision making process had not been followed prior to the submission of the DoLS applications. This would ensure applications were only made when required. It was not clear therefore whether a DoLS was required for all people or not and if required, whether this had been authorised.

A person's relative told us they were not aware of the DoLS application for their relative and added "I don't think they (person) would understand the arrangements in place, it's just always been her life and she would not think about it or consider it to be strange". It is important to establish whether people have the mental capacity to agree to any restrictions that may amount to a deprivation of their liberty and that where

required a lawful authority is in place.

Staff had completed training in the Mental Capacity Act 2005 and were aware of how to support people to make their own decisions about their day to day care. Where people were able to make decisions and self-care they were supported to do so. For example; one person managed their finances and self-administered a daily medicine. People's care plans included information about how best to support people with their decisions such as; how people liked to communicate, the best way to present choices; how to help the person understand; and the best time and a bad time to make decisions. People were supported to make decisions about their day to day care.

A person's relative said "We are blessed with pretty good staff. With the (registered) manager off the nucleus of staff is good. Continuity of staff is good and they have the best interests of the people at heart, I have confidence in them". Staff had completed an induction into their role and this included shadowing experienced staff. A staff member told us "I had no experience of care before I came here, so it was really good that I got to know people's needs with other staff". Records showed new staff completed a programme of induction training within the first 12 weeks of their employment. This included training in; health and safety, infection control, medicine administration, equality and diversity, food safety, safeguarding and the Mental Capacity Act (2005). People were supported by staff who received an induction into their role and people's individual needs.

Staff completed training to meet people's individual needs. For example; all people living at Tudor Rose used Makaton as a means of communication. For two people this was their main communication method. Makaton is a language programme using signs and symbols to help people to communicate. All the staff were trained in the use of Makaton. This meant people's communication needs were met by staff who used people's preferred method of communication. Other training to meet people's individual needs included; autism awareness and epilepsy awareness.

Staff training records showed a range of training opportunities were available to support staff with their professional development. For example, a senior support worker had completed training in; first line management, manager medication, and supervision and appraisal skills. Records showed staff received regular supervision and an annual appraisal. Staff told us they received 'good' management support. People were supported by staff who received an appropriate level of supervision and training to carry out their role effectively.

A senior worker was responsible for monitoring people's support needs in relation to their nutrition. This included a nutritional screening assessment; weekly weights and weekly food groups monitoring. This information was used to identify any concerns so these could be addressed. For example; people at risk of poor nutrition and weight loss were monitored so that if they lost weight their diet could be adjusted to include higher calorie food supplements to help them maintain a healthy weight. A person's relative told us their relative had a weight loss problem and said "they monitor the trend now; they have worked really hard with her and she has gained weight".

A Speech and language Therapist (SALT) had been consulted about a person's changed eating habits that resulted in weight loss. Staff implemented strategies to help the person regain an interest in food which was successful and the SALT referral was closed. This meant staff took action to ensure people at risk of poor nutrition were effectively supported.

People were involved in choosing the foods they ate. Records showed menus offered a varied diet that included fresh fruit and vegetables. Information was kept on people preferences such as the fruits they liked

and didn't like. One person's relative said "they chose what they eat and they eat better than most!" People were supported to meet their nutritional needs and preferences.

Records showed people had all received an annual health check with the GP and health checks for the year were planned. People had a Health Action Plan (HAP). The HAP detailed the actions needed to maintain and improve the health of an individual and any support needed to achieve these. This included all aspects of people's health needs and the healthcare professionals who supported them. Where people attended an appointment the outcome of this appointment and any follow up required was recorded in their HAP so actions could be monitored and reviewed. This meant people's healthcare needs were monitored effectively.

Information about people's health needs was person-centred and included their individual needs such as how they expressed they were in pain or feeling unwell. People's relatives told us they were satisfied with the management of people's healthcare needs. They confirmed staff acted promptly to ensure people received treatment as and when required. One relative told us their relative did not like going to the GP. They said "They (staff) have worked on that and now she will go to the GP and have her blood pressure and her annual exam – how thrilled the staff were with her". People were supported to meet their healthcare needs.

Good

Our findings

People living at Tudor Rose had lived together for a long time and since attending junior school. Staff told us they like to be known as the 'Ladies of Tudor Rose'. One person told me her friends were the other women living in the home and relatives and staff described the relationships between the women as 'sisterly'. Some staff had also worked at the home for many years. Relatives spoke about the value of the staff continuity in building positive relationships with people who knew them well.

People's relatives told us that staff were caring. One relative said "We are quite happy our daughter will be looked after there when we are not here. We wouldn't want to see her anywhere else". Another relative said "I think staff do care, the continuity shows they care and they have come in on their day off for example".

Staff told us about the people they supported. This included people's likes and dislikes. For example a staff member said "She likes church and going out with friends she is very sociable. She doesn't like you to prompt her. We need to be very aware of her crossing the road". Staff spoke about people with warmth and understanding and a staff member said "We are all trained in Makaton so people can communicate with us at their comfort. We make time for conversation with all of them and we all have a laugh and a joke– they know we are all here for them and they know it's OK to talk to any of us". One person was keen to tell me about their keyworker and immediately said "she can sign using Makaton". We observed a staff member using Makaton and noted that people were comfortable and confident with staff.

Staff were aware of people's needs when they became distressed. For example a staff member said "It would depend on who it is one person would like to have a cup of tea with you and another person prefers to be left alone". People were supported by kind and compassionate staff.

House meetings were held to enable people to contribute to decisions and express their views. Minutes showed people had discussed; keyworker changes, menus, health and safety issues involved with the building works and any issues they wanted to raise. Minutes of these meetings were produced in word and pictorial form to enable people to read and understand them. People were supported to express their views and make decisions.

The registered manager said "We all get involved in everything – when we buy a new cushion we all have a say". During our inspection we observed people were discussing the changes being made in the building. People were being consulted about colours and objects to keep or change.

The registered manager told us how they supported people to express their feelings. They said "A lot of what goes on here is the ladies struggling to express their feelings. So I have taken a word and used song and drama to help people understand what that feeling word means – I try to engage people practically and involve them". Records showed a person had been supported through a range of strategies to help them communicate feelings and this had helped to alleviate their distress and behaviours that may challenge others.

A person's relative said "If staff go to her room with the phone they always knock, I hear them. They do make sure she dresses appropriately but they can't force her as sometimes she chooses to wear inappropriate shoes". Staff told us people could chose who supported them with their personal care. The staff team was all female with the exception of the interim manager and people were supported with their personal care needs by female staff only. People's relatives told us staff treated people respectfully and supported them with their decisions and choice. A staff member told us how at times people may not be aware of maintaining their own privacy and dignity and said "We ensure they have the privacy and dignity they deserve even if at times they don't realise it. For example; always ensuring curtains are closed for personal care". People were supported in a dignified and respectful way.

One person who communicated using Makaton and writing, wanted to make more friends but felt restricted because others were not able to communicate using their preferred methods. Staff told us how the person had been supported by a SALT with communication aids and now used an electronic tablet to communicate with a range of people. This had enabled the person to build friendships with others in private without the need for staff interpreting. People were supported to enjoy private relationships.

Good

Our findings

A person told us about the activities they enjoyed which included; shopping, mumbo jumbo (doing creative things), horse riding, going to the library and the church, menu planning and Makaton groups. They told us how they cleaned their bedroom and saw their friends. They talked to us about their family as there were photos to reference them in their bedroom, and plenty of dolphins which they told us were a favourite.

A staff member said "The ladies are non-stop doing something. They lead an active life and do a lot together but if they don't want to do something as a group they can stay back with staff for example; two people may go swimming and two people prefer a walk". People's care plans described the interests that were important to the person and a relative told us how a person was supported to enjoy these interests. They said "she doesn't want for anything". People were supported to meet their interests and activity needs.

People's care plans were person-centred. Information was included on the people and relationships that were important to them and how these were maintained. For example, people used Skype and electronic tablets to keep in contact with family and friends. Other individualised information included; what people like and admire about me, how I prefer to be supported, what's important to me and my typical day. Information was included on how to support the person to have a 'good' day. Care plans described what people could do for themselves such as; make breakfast, have a bath and getting dressed. People's care plans reflected their individual needs, preferences and abilities.

People's daily care was recorded in a monthly workbook; entries included people's daily activities along with what they had done for themselves and the support they received from staff. The workbooks were reviewed monthly with the person. This enabled staff and people to review their needs and evaluate how they were progressing in their identified goals and their accomplishments. For example; a person had been praised for managing the changes brought about by the building works. People were involved in regular reviews of their care and treatment. When people's needs changed these were updated on their care plan and noted on a care plan review sheet to guide staff when changes were made.

Person centred reviews were carried out annually and these included other people involved in the person's care, such as; social workers and relatives. The review included an account of what was working and not working and actions were required to improve the care and treatment people received. For example; one person's review identified all staff required training in autism awareness and this was planned to be completed by all staff. People's care plans reflected their changed needs and care was planned and delivered to meet these.

When people experienced changes in their behaviour staff acted promptly to ensure the person received appropriate support. For example; a person who had behaviours that challenged others was referred to a psychologist and a SALT. The registered manager worked with the person's relatives and these other professionals to develop guidelines and interventions to support the person to manage their behaviours. Records showed detailed guidance was in place to guide staff on how to respond to the person to minimise the risks to the person and others from these behaviours. Staff told us about how they supported the person and this was consistent with the guidelines. A relative said "She is a lot happier now and her life is much better. I felt really supported by the manager and staff they kept me in the picture and tried so many things". People received the support they required to improve the quality of life they experienced and achieve positive outcomes.

Information was displayed in the home on how to make complaints. This included information in easy read and pictorial form to meet people's communication needs. The provider had a procedure in place which explained how complaints would be dealt with. The procedure included the monitoring of complaints by the provider's compliance team to ensure complaints were dealt with appropriately in line with their procedures. We looked at the record of complaints and saw none had been recorded since our last inspection. People's relatives told us they knew how to raise concerns and were confident these would be dealt with. One relative said "I am absolutely able to raise concerns with the manager. There have been issues raised with the operations manager and these have been sorted".

Good

Our findings

A registered manager was in post, however they had been absent from the service since 13 November 2015. The absence of the registered manager had been unexpected and we were notified about their absence on 12 January 2016. This was because their absence had exceeded 28 days. The registered manager was expected to return in March 2016 although this had not yet been confirmed.

The provider had appointed an experienced interim manager known to the organisation during the registered manager's absence. This person worked three days per week. The operations manager was available to support the staff when the interim manager was off duty. Staff confirmed the arrangements in place were adequate. A staff member said "I feel listened to by managers and I can raise concerns". Another staff member said "Team morale is generally good – at the moment we are all under pressure. (Due to building work). We have sat down and discussed this. The team effort on a good day is fantastic – it's faultless. We can discuss issues it's a good place to work". Staff were supported to understand their role and responsibilities through individual supervision and team meetings. Records confirmed these were carried out regularly by the registered and interim managers.

Staff told us how they demonstrated the provider's values in their work. Staff spoke about their commitment to treating people respectfully, valuing people and developing trust in their relationships with people. The registered manager and interim manager described how they monitored staff behaviours with people. This included; working alongside staff to observe and evaluate staff interactions. The interim manager said "The office door is always open so I can hear staff, they do talk to people respectfully and I hear a lot of 'come on let's do this together'. I don't think people would be as happy as they are if there were any troubles with staff".

People's relatives told us the culture at Tudor Rose was 'open' and they had a good relationship with the registered manager who was responsive to any feedback or concerns. Relatives told us the absence of the registered manager had some impact for example; during their absence relatives said they had not experienced the same level of interaction from the provider and felt this had fallen short over the building works and increased occupancy plans. However, one relative said "I have spoken to the operations manager about this and we have been promised a full service resources review prior to the admission of another person". They told us they were satisfied with this response. People's relatives were concerned about the impact of a new person into the home and staffing arrangements. The operations manager and staff told us their priority was to ensure, as far as they were able, the compatibility of a new person coming into the home. For example; they told us it would be important for the new person to use Makaton so that people

could communicate with each other.

People's relatives were asked for their feedback about the service. A questionnaire had been sent out in November 2015, shortly before the registered manager's absence. The interim manager told us one relative had responded and we looked at this response. Feedback about the service was mostly complimentary; the issues they had raised were being dealt with through the refurbishment and the provider's response to facilitate a resources review. Relatives we spoke with confirmed they were able to give their views and these were acted on. For example; a person's relative said; "I have been asked for my views and 99% of any problems are dealt with by the manager".

Records confirmed people were asked for their feedback about the service at regular house meetings. People were also able to discuss their feedback in their monthly meetings with their keyworker. Staff told us how they had supported people to express their views about the building works and one staff member said "This has been listened to and acted on". People and their relatives were asked for their feedback about the service and this was acted on.

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Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Records showed this included audits by the operations manager and the service manager. Actions arising from audits were compiled into a consolidated action plan which was reviewed quarterly by the operations manager. The auditing system was based on the requirements of the Health and Social Care Act Regulations (2014) called the 'fundamental standards'. We reviewed the action plan for October – December 2015 and saw actions were being completed as required, this included repairs to faulty equipment and regular safety checks. This ensured a system was in place to drive continuous improvements to the service people received.

An incident reporting system was in place. Incidents were recorded by staff and checked by the manager. Incidents were monitored by the operations manager and the provider's compliance team to ensure action was taken as required. Information from incidents had been used to support changes to a person's care and treatment which had resulted in a reduction of adverse incidents and a positive outcome for the person. Records showed incidents had been recorded and appropriate actions taken.

Health and safety checks were undertaken to identify any risks to people's safety from equipment and the environment. For example; there was evidence of checks in relation to water temperature, fridge and freezer temperatures, tumble dryer filter checks and monitoring equipment. Regular fire drills were carried out with people and issues such as hand hygiene were discussed with people at meetings to promote people's understanding of health and safety issues.