Leonard Cheshire Disability

Stonecroft - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We undertook this unannounced inspection on the 22 and 23 October 2014. The last inspection was completed on 17 December 2013 and the service was meeting the regulations we assessed.

Stonecroft Care Home can support up to 29 people who have a primary need of physical disability. The service is situated in an old detached building set in a quiet location so transport is essential. Although there are two floors, all the services for people are on the ground floor. The upper floor is used for administration and staff training purposes. All the bedrooms are designed for single occupancy, eight of which have en-suite facilities. There are sufficient bathrooms and communal rooms for people to use.

The service had a registered manager who had been in post since 2006. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Staff had completed training in how to protect people from abuse but there had been times when incidents of potential harm had not been recognised as such and had not been discussed with the local safeguarding team for advice and guidance. You can see what action we told the registered provider to take at the back of the full version of the report.

The environment was safe, equipment was checked and maintained and risk assessments were carried out.

There was sufficient staff on duty day and night to meet people's needs. Staff, received training and support so they would feel confident and skilled when supporting people.

When people were assessed as lacking the capacity to make their own decisions, meetings were held with relevant people to plan care which was in the person's best interests.

People had their health and social care needs assessed and person-centred plans were developed to guide staff in how to support people. The plans of care were detailed and included routines and preferences for how care should be delivered. People who used the service received additional care and treatment from health professionals based in the community.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities via the use of minibuses and there were activities arranged in the service by staff and volunteers. People were able to make suggestions and raise concerns.

The registered provider had a quality team which completed a series of annual audits and questionnaires. The registered manager and staff team monitored the quality of the service on a day to day basis but management checks had not identified some decision making, recording and environmental issues.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although staff had received training in how to safeguard people from abuse and harm, there had been instances when staff had not recognised that potential abuse had occurred. They had not contacted the local authority safeguarding team to discuss the issues and seek advice. This could place people at risk of further harm.

People who used the service and their relatives told us they felt safe living in Stonecroft Care Home. Risk assessments were completed, equipment was maintained and medicines were managed safely.

There was sufficient staff to meet people's assessed needs. Recruitment checks were carried out to ensure only appropriate staff worked with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff received support, essential training and specific training in conditions that affected the people who used the service.

The registered manager made sure that any restrictions placed on people's liberty were authorised legally by the local authority. Staff gained consent to care and treatment and when people were unable to provide consent, they discussed care with relevant people and carried this out in their best interest.

People had their nutritional and other health care needs met. We observed staff support people to eat and drink in an appropriate way and there was access to food and drinks during the day and at night. Records showed people had visits from a range of health professionals.

Is the service caring?

Good

The service was caring.

We observed staff promote privacy, dignity, choice and independence. They spoke with people in a respectful way, were professional but also had friendly banter with them.

People were involved in decisions about their own care and also in how the service was managed. Meetings were held with people who used the service. These meetings were chaired by one of the people who used the service.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People had assessments of their needs completed prior to admission and when their needs changed. Plans of care were developed from the assessments, personal histories and risk assessments. These ensured staff knew how to care for and support people in line with their preferences and routines.

People were able to participate in activities and leisure pursuits. There was transport provided to ensure people could access community facilities.

People's niggles, concerns and complaints were addressed. People told us they felt able to raise concerns with staff and they were confident these would be addressed.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

There have been some instances when the Commission were not informed of incidents that affected the welfare of people who used the service. Although there was a quality monitoring system in place that consisted of audits and surveys, management checks had not identified some decision making, recording and environmental issues.

People told us the registered manager was supportive and approachable and they could speak to them about issues knowing they would be sorted out.

The registered provider had a well developed vision, a mission statement and a set of values which guided staff in their practice. It also provided an ethos of ensuring people's rights were upheld, treating people as individuals and improving their quality of life.

Stonecroft - Care Home with Nursing Physical Disabilities

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 23 October 2014 and was unannounced.

The inspection was led by an adult social care inspector who was accompanied by an expert 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. The expert by experience had experience of the care needs of people living with a physical disability.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received information from a health professional who visited the service and we contacted the local safeguarding of adults team for information.

Prior to the inspection we looked at the notifications we had received from the registered provider. These gave us information about how well the registered provider managed incidents that affected the welfare of people who used the service.

During the inspection we observed how staff interacted with people who used the service. We spoke with six people who used the service, two of their relatives, the registered manager, the care supervisor, one nurse, two care staff, a physiotherapy assistant, the cook and a housekeeper.

We looked at three care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service. These included several medication administration records (MARs), assessments carried out under the Mental Capacity Act 2005 and the two Deprivation of Liberty Safeguards that had been authorised by the local authority.

We looked at a selection of documentation relating to the management and running of the service. These included six staff recruitment files, the training plan and record, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records.

We completed a tour of the premises to check on cleanliness and hygiene.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Stonecroft Care Home. The said, "I like living here" and "It's good here."

The service had safeguarding policies and procedures in place. The registered manager told us these guided staff to use local safeguarding procedures. The registered manager had recently been made aware of local procedures regarding a threshold tool to be used when gauging risk and referring allegations of abuse. This information had not been cascaded to other senior staff that would be in charge of shifts and when spoken with they were unsure of the system. This was mentioned to the registered manager to ensure all senior staff in charge of shifts were aware of the local safeguarding threshold tool and referral procedures. The registered manager confirmed this would be completed as soon as possible.

When we checked the accident reports for the last 12 months we found there were four incidents which should have been discussed with the local safeguarding team. We discussed these with the registered manager and care supervisor who stated they would speak to the safeguarding team to log them retrospectively. This meant there had been a breach of the relevant legal regulation (Regulation 11 (1) (a) (b)) and the action we have asked the registered provider to take can be found at the back of this report.

One of these incidents referred to a nurse consulting with a relative on the need for a person to visit A&E following an injury to their hand. Other than a small mark, there were no obvious signs of injury after the initial assessment. Whilst it is good practice to consult with relative's involved in people's care, this should have been a clinical decision by the person who had observed the injury. The decision resulted in a one day delay of treatment for a fractured finger.

Nearly 80% of staff had received training in how to safeguard vulnerable people from harm and abuse. A further course had been arranged in December 2014 for the remaining staff. In discussions, staff were aware of the different types of abuse and the signs and symptoms that would alert them to concerns. They said they would report any concerns to their line manager. They said, "I would make sure the person was safe, ensure staff stayed with them and report it to the manager" and "You can report concerns to the area manager if necessary."

The administrator provided information on how people's monies were managed when it was held for safekeeping. The system ensured records were maintained, receipts for purchases obtained, two signatures were on each transaction and monies were held securely. This helped to protect people's money from misuse.

We found there had been a moving and handling incident with a ceiling track hoist in August 2014 which had injured a person who used the service. The Care Quality Commission had received a notification about this incident. It had been investigated by the service and was overseen by the local safeguarding team. Recommendations were made for staff to follow moving and handling guidance. There had also been a previous incident in April 2014 when a ceiling track hoist had spun round and caught a person on the lip. Although there was no injury reported, it caused discomfort. We spoke with staff about the hoist incident in August 2014 and they had all been made aware of it, risk assessments had been updated, training implemented and lessons learned so that practice could be improved. Staff said, "I have changed my practice, I make sure my hand is between the person and the hoist in case their head moves."

We saw that risk assessments had been completed for areas of need such as moving and handling, nutrition, specific health conditions, falls, choking, skin integrity and the use of bedrails. The risk assessments provided information to staff on how to support people safely and to minimise risk. For example, one person had a serious medical condition and the risk assessment detailed what this was, the signs and symptoms to look out for and what to do if staff observed them. Staff were aware of the risk assessments and told us they had time to read them and received information in handovers when they were updated.

There was a system in place for ensuring equipment was serviced. We checked a selection of records and saw equipment such as hoists, suction machines, the fire alarm and nurse call systems, specialist baths, portable electrical appliances and gas appliances were serviced regularly. Maintenance personnel kept a folder of the checks they completed such as hot water outlets to ensure they

Requires Improvement

Is the service safe?

remained a safe temperature and hoist slings to ensure they were not frayed. These checks enabled staff to identify issues that required attention and helped to maintain people's safety.

The registered manager had plans in place for foreseeable emergencies. First aid kits were available and each person who used the service had a personal emergency evacuation plan in case of a fire emergency. Staff prepared for fire emergencies by participating in fire drills and they told us there was a file to use in case of emergencies which had important telephone numbers and information. The cook told us that prior to the winter months they ensured food stocks were enhanced. There was also a staff sleep-in room for use when required. These two measures were because the location of Stonecroft Care Home meant there was the possibility of limited access when it snowed.

There was a care staff structure which consisted of the registered manager, a care supervisor, qualified nurses, team leaders, senior care assistants including some who have a senior role, activity coordinators and a physiotherapist assistant. In addition, there were ancillary staff for catering, domestic, maintenance and administration. Staff recruitment files showed that full checks were carried out prior to their employment in the service. This helped to ensure only suitable staff were employed to care for vulnerable people.

There was sufficient staff to meet the needs of people who used the service. The registered manager described how they calculated the amount of staff they needed each week. This was done by assessing the number of hours of assistance required, day and night, for each person who used the service. As the service provided respite care for some people, these staffing levels were adjusted when needed. The staff rotas indicated a number of staff who were employed on 'occasional hours' contracts and staff confirmed they were used to complement the staffing numbers to meet people's changing needs or admissions for respite care. Staff said, "We can get more staff, they come in for end of life care" and "No problem, we can get staff at short notice; last week we had extra." One visitor told us they thought that at times there was not enough staff especially at weekends and this could lead to their relative having to wait for assistance. A person who used the service said, "When I press the call button for a drink, I can sometimes wait a while for them to come". The registered manager and staff confirmed there was the same number of staff at weekends as during the week but they would take note of this comment and monitor call response times.

We saw medicines were managed safely with systems in place to ensure they were ordered promptly and checked when delivered. The service had a designated treatment room where medicines were stored in trollies (for everyday use) and cupboards. There was a controlled drugs cupboard and a fridge for medicines that required more specialised storage arrangements. We checked a selection of medication administration records (MARs) and found these were recorded accurately. When people were prescribed medicines to take 'when required', there was guidance for staff attached to the MAR. We observed a member of staff administer medicines to people. This was completed safely with checking mechanisms in place to ensure the medicine was given to the correct person. People who used the service told us there were no issues with medication. They said they received them at the same times each day and assistance was given if needed. A nurse spoken with confirmed they completed annual competency checks to ensure they remained safe to administer medicines.

Good

Is the service effective?

Our findings

People who used the service told us, “Staff seem to know what they were doing.” People said they liked the meals but there were some mixed comments about the variety. People said, “The food is ok”, “The quality depends on which chef is on duty” and “I like the choice we have but it can be monotonous.” A relative said “The menu is boring; yes they have a choice but they are the same things all the time. I don’t think crumpets are enough for tea and they puree kippers which is not very appetising.” We followed up some comments with the registered manager and found these had already been addressed with catering staff.

People had their nutritional needs assessed on admission using a specific tool and care plans provided information on likes, dislikes and food preferences. Monitoring charts were used to record people’s food and fluid intake when required and their weight was recorded at intervals guided by the risk assessment. We saw that dieticians and other health care professionals such as speech and language therapist and GPs were involved when there were concerns about people’s food and fluid intake.

We looked at menus and spoke to the cook on duty. The menus ran over a four week period and the cook said they spoke to people about the contents of them and added dishes when suggestions were made. They checked the day before to see what choice people wanted for the meals at lunch and tea time. We observed the cook completing this task. We observed the cook served lunch from a heated trolley, which assisted staff at the busy lunchtime period. The cook was aware of preference for portion size, which people had food allergies, and who required a special diet such a soft, pureed, vegetarian and diabetic. They had written information about a small number of people’s nutritional needs but not for every person who used the service. This was mentioned to the registered manager to address. There was a plentiful supply of fresh fruit, salad and vegetables and sufficient stocks of fresh and frozen meat and fish.

We observed the lunchtime experience for people who used the service. Staff supported people to eat their meals at a pace that reflected their needs. They sat next to people and chatted to them, they checked if people had eaten enough and they offered drinks. We observed some people had chosen an alternative to the main meal. People told us there was a choice for both lunch and the evening meal.

Care records confirmed people had access to health care professionals for advice and treatment such as GPs, consultants, specialist nurses, dieticians, occupational therapists, physiotherapists and speech and language therapists. People spoken with confirmed they saw opticians and chiropodists. A relative said, “I think the dentist visits but I’m never informed”. A member of staff said, “We call the GP straight away or the out of hours doctor; we get to know people and we know when they are not well.” We spoke with a physiotherapy assistant who confirmed they completed treatment plans. These were devised by a physiotherapist who visited fortnightly and a technical instructor who visited once a week as part of a contract the service had with the Rehabilitation Medicine Service. Wheelchair clinics were held at the service to ensure people’s needs were reviewed and modifications made.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. In discussions, it was clear the registered manager had a good understanding of their responsibilities in relation to DoLS and was up to date with recent changes in legislation. They had made applications to the local authority to ensure appropriate assessments were carried out when people were deprived of their liberty. The applications included some people who lived at Stonecroft Care Home and others who used the service for respite breaks.

Training records showed that staff had completed training in the Mental Capacity Act 2005 (MCA). In discussions staff showed an understanding of the principles of MCA and described the actions they took to ensure they obtained consent prior to care and treatment. Staff said, “We ask people, check if they want to get up or go to bed. People can make their own decisions.” We saw mental capacity assessments were completed when there was doubt about a person’s capacity to make their own decisions and best interest meetings were held to plan care. Staff said, “We have a formal questionnaire to use to assess capacity; we talk to the family and GP.”

The training plan included courses to be delivered over the next three months at the service and at other services within the organisation. Staff were able to access these courses at each service. The registered manager told us the

Good

Is the service effective?

registered provider was in the process of altering how training was delivered. This was to be organised centrally rather than within each service. Records of completed training were computerised, as the service moved away from paper records. The computer records were accessible to the registered manager and they were able to supply information about which staff had completed specific training.

Staff confirmed they completed training that equipped them with skills required to support the people who used the service. The training included essential training such as first aid, moving and handling, safeguarding, fire safety, infection prevention and control and basic food hygiene. In addition, staff said they completed other training such as catheter management, bowel management, wound care and conditions affecting people who used the service. A team leader confirmed they had received training to aid their development to complete delegated tasks such as how to use suction machines, how to take people's blood pressure and how to monitor their blood glucose levels. A nurse said, "We have plenty of training. Some training we would only have when we need it such as syringe driver training. We don't use these very often and we would need refresher training each time someone has one."

Staff confirmed they had supervision meetings and could approach the registered manager or senior staff for support on a daily basis. The care supervisor told us some supervision meetings and appraisals were a little behind schedule but these were to be addressed in the next two months. One member of staff described their induction and said they had received good support during their probationary period. They said, "I had initial training such as moving and handling and shadowed a team leader. Then I completed a computer course and worked through sections such as safeguarding, food and personal care; it took about three months." Staff said, "We can discuss issues at any time" and "Staff can come to us (seniors) at any time and they certainly do." Staff confirmed they had handovers at each shift and were able to pass on important information.

The building had been adapted to meet the physical needs of people who used the service. There were ceiling track hoists in each bedroom and bathroom, specialised baths, moving and handling equipment, wide corridors for people who used wheelchairs, ramps and automated doors to the entrance. There was also a range of crockery and cutlery designed to meet people's individual needs.

There was a range of communal rooms inside the building and several outside areas, which responded to the varying needs of people who used the service. For example, there was a large dining room, several lounges, one of which was set up with desks and computers and another had a kitchen attached, a sensory room, a room for people who wished to smoke, an art and craft room and a physiotherapy treatment room. Externally, there was a sensory garden, a courtyard with raised beds, a patio leading from one of the lounges and a grassed area to the side of the property used to house a chicken run. A path around the garden area was in need of clearing and was a little uneven in parts but the registered manager was aware of this and was to raise it with volunteers.

Good

Is the service caring?

Our findings

People who used the service told us, “The staff are very friendly” and “I like it here, the staff are really good”. They said staff were kind and caring. Some people told us they preferred more mature staff to support them although this was not always possible, as the staff team was a mix of younger care workers and more mature staff. A relative said that communication could be better; we mentioned this to the registered manager to address. People told us they had a key worker and said they had built good relationships with them. We observed staff speak with people in a patient and considerate way. For example, they chatted to people, asked if they were warm enough, assisted appropriately at lunchtime, made sure people took their medicines safely and they constantly asked if anyone needed drinks.

In discussions with staff they demonstrated an approach to supporting people that was caring, compassionate, promoted choice, privacy and dignity, and encouraged independence. For example, staff said, “I look after residents how I would want to be looked after”, “I do believe people are cared for well here”, “People have a choice of male or female carer”, “This is their home and they are treated with respect”, “I love working here”, “We close doors and curtains, knock on doors and give explanations; one person is able to bathe themselves” and “When we clean people’s bedrooms we always make sure things are put back in their right place.” We observed staff support a person to adjust their clothing, which preserved their dignity.

All the bedrooms were for single occupancy and eight of them had en-suite facilities. There were privacy locks for bedrooms, bathrooms and toilets. This helped people to have their own space and privacy.

Documentation and discussions with staff, people who used the service and their relatives, assured us information was provided to people and they were involved in planning the care they received. Staff respected decisions made by people who used the service. For example, care plans detailed preferences for how care was to be delivered and daily records described when care was declined or when specific care was requested. Staff had recorded entries in care notes that read, “Declined bowel management as they said they didn’t need it”, “Requested to get out of bed for a cigarette at 11pm” and “Assisted to put on a face mask as requested.”

Meetings were held which were chaired by a person who used the service. The minutes of these meetings showed that people were consulted and involved in decisions such as planning activities and choosing colour schemes for decoration and refurnishing. We saw notice boards which provided information to people who used the service on how to keep safe, how to contact the customer support team, how to make a complaint, and how to access advocacy services. There was additional information on the ‘Customer Action Network’ (CAN) and the minutes of the last meeting. CAN meetings were held regionally by the registered provider and a representative from Stonecroft Care Home had the option of attending. One of the people who used the service attended the meetings and put forward views and suggestions about the service.

The care supervisor showed us a new care plan that had been designed to assist staff when planning end of life care with people who used the service. The documentation provided people with the opportunity to be involved in advanced decisions and to ensure their wishes were known and respected. Staff had not supported anyone at the end of their life in the last year but they described how support would be provided. They told us one person had held a meeting with their family and health professionals a few months ago as their condition had deteriorated. Decisions were recorded regarding their wishes and medicines were received to use for pain relief as required. The staff said the person had recovered and they no longer required palliative care but they were aware of their wishes should the person’s health deteriorate again. One member of staff said, “It is always our thing to make sure someone doesn’t die alone.”

Good

Is the service responsive?

Our findings

There were two care files for each person who used the service. One was their day to day support plan and the other contained health information and guidance for staff. The care files contained assessments, risk assessments and support plans. The care files and plans described care and support that was person-centred (tailored to people's individual needs).

The support plans had personal profiles, information about what was important to the person, their daily routines, what they could do for themselves and what they required support with. For example, one support plan had photographs of how the person preferred their limbs to be positioned when they were in bed. It described how they picked up their phone and the limits to their dexterity when rolling cigarettes and lighting them. Another person had a very detailed plan to describe what support staff had to provide to meet their nutritional needs. The care file also had guidance for staff in how to manage the person's epilepsy, what a 'normal' seizure looked like for them and how to support them when one occurred. One person had a pressure ulcer that had developed when their physical health had deteriorated, despite the care provided by staff. A nurse told us that now the person's health had improved, the pressure ulcer was improving. They said, "The sore is clean and we have been looking at diet to encourage regrowth."

People were supported with their diverse needs. The cook told us they would be able to meet specific people's cultural and religious needs regarding meals, but relatives preferred to bring in meals they prepared and this was respected by staff.

Bedrooms were personalised with people's own belongings, pictures, books, phones, computers, fridges, radios and televisions. This showed us people had their own space and could decorate it how they choose. The registered manager showed us one person had a system to make it easy to control their environment.

There were notice boards at an appropriate height for people who used wheelchairs. These had information about menus and planned activities, some of which were provided by volunteers. These included games and quizzes, craftwork, keep fit, music sessions, computer club, baking and watching DVDs. People had access to local facilities such as supermarkets, garden centres, shops and pubs. The service had two minibuses and a car to provide transport for people. This was important as the service was set in a quiet and isolated location. One person said, "I like to go shopping and to the theatre; I say where I want to go and they arrange it."

The service had a range of communal space which enabled people to participate in specific activities. For example, one person liked to make model aeroplanes in the art and craft room, one person enjoyed tending the raised flower beds and another person was involved in caring for the chickens.

Every person we spoke with said they felt confident they could raise concerns and that these would be resolved. There was a complaints policy and procedure and all complaints were documented. People who used the service said, "I would go to my keyworker first if I had a problem", "They will sort it out if I am not happy" and "We raise any concerns or worries and they do their best to put it right." A relative said, "We do not hesitate in speaking with the manager if we are not happy about anything." Staff told us there had been plans to remove the chickens but one of the people who used the service complained about this. Staff supported them with their complaint and the decision was overturned.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection the service had a manager who had been registered with the Care Quality Commission since October 2010. They had been in post since 2006.

We found quality audits were completed annually by the registered provider's quality team. The audits highlighted shortfalls and the auditor produced an action plan with timescales. The registered manager said this was followed up with them during monthly visits by the area manager. This external scrutiny ensured senior management oversight to systems and practices in the service. In addition to annual audits there were internal checks such as a weekly medicines audit and daily environmental checks. The service had cleaning rotas for bedrooms and communal areas. A house keeper said, "I walk around the floor daily and check bedrooms and communal rooms to see what jobs need doing."

Although the quality monitoring system was in place, there were instances when management checks had not highlighted some decision-making, recording and environmental issues. Some accident reports did not include full information of the incident and the action taken. Although the Commission usually received notifications of incidents that affected the welfare of people who used the service, there were four notifications which we had not received. A high voltage cupboard was unlocked and seen to have household items stored inside when a notice on the door stated it was not to be used as a store cupboard. A store room for products used with suction machines, care of tracheostomies and catheter management did not have an effective stock rotation system. These issues were discussed with the registered manager and care supervisor and they have assured us they would be addressed.

We saw the audits had identified areas for refurbishment and a significant budget had been agreed for this to go ahead. There had been a delay in starting the refurbishment but it was planned to be completed before March 2015. Included in the refurbishment were all the bathrooms, the entrance and main corridor, some work in the main and small kitchens and other communal areas. The refurbishment would help to improve the quality of services for people.

We spoke with the registered manager and staff team about the culture of the organisation. The registered manager showed us the provider's Vision, Mission and Values statement which was on display in the service. This described ensuring people's rights were upheld, treating people as individuals and improving quality of life. In discussions with staff and in records written about people we saw the vision, mission and values working in practice.

The service had 'Investors in People' status. This was an accreditation scheme that focussed on the registered provider's commitment to good business and people management. The registered manager told us they were on the steering group of the North Lincolnshire Cross Sector Partnership Group. This was to improve working relationships between important organisations involved with people's care, treatment and support. We saw the service worked closely with Rehabilitation Medicine Service and the local authority physical disability and learning disability teams.

The registered manager said, "We have an open, caring and effective service. Staff are honest with me and will raise issues; I may not always agree with them but I will try to resolve issues." Staff said, "It's a happy place, we have a good staff team and we work well together" and "There are incentives for staff such as long service awards, pay increments and increased holiday time up to a maximum of five years."

People and their relatives spoken with told us the registered manager was approachable. One person said, "Management is ok." Staff said, "The manager is approachable; you can go to him with anything. We also see the area manager. He visits and talks to staff and service users" and "The manager spends time in their office; he knows his job, how to organise and how to cascade information" and "I would be able to whistle blow if needed." Staff spoken with were clear about their roles and responsibilities. They described the tasks they completed to ensure people's needs were met. We saw that staff received job descriptions and terms and conditions. The registered manager was making sure job descriptions were up to date.

There were meetings for people who used the service and also for staff, although the latter had not been as frequent as originally planned. The minutes of meetings showed us people were able to express their views about the running

Requires Improvement

Is the service well-led?

of the service. Topics included, decorating choices and updates, proposals for refurbishment, activities, outings, fundraising, volunteers, staff practices, reminders for staff and passing on information.

We saw there were annual questionnaires for people to complete about their views on the service provided, although there were no in-house surveys to complement this. One of the two relatives spoken with told us they had filled in a questionnaire but the other relative was not aware of them. A person who used the service said, "I think I have filled in something like that". We saw the 'customer survey service action plan', which was completed following the annual survey in March and April 2014. This had identified areas where the service was doing well and some areas that required improvement. It identified the action to be taken, who would be responsible for this and a timescale for completion. The results of the survey were incorporated into a 'You said; we did' form and placed on the notice board for people to see. This showed the provider had listened to people's views and had taken action to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: People who used the service were not protected against the risks of abuse and harm because suitable arrangements were not in place to ensure staff were fully able to identify the possibility of abuse and to respond appropriately to any allegation of abuse. Regulation 11 (1) (a) (b)