SHC Clemsfold Group Limited

Beech Lodge

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?	Requires improvement

Overall summary

The inspection took place on 6 and 8 July 2015 and was an unannounced inspection.

Beech Lodge is registered to provide accommodation and nursing care for up to 40 people. The home comprises Beech Lodge, Oak Lodge and Redwood House. At the time of this inspection Redwood House was being used as a day centre and did not form part of this inspection. This is because day centre services are not regulated by the Care Quality Commission. The home is purpose built and well-equipped. It caters for young adults with physical and learning disabilities or autism. At the time of our visit there were 25 people living at the service, 17 in Beech Lodge and eight in Oak Lodge.

The service has a registered manager but this person was no longer working at the home. A new manager was appointed in October 2014 but had not yet made an application to register with us. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who has

Summary of findings

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. We found that the provider had not taken satisfactory steps to comply with this condition of their registration.

The service had been the subject of a safeguarding enquiry by social services following two incidents in April 2015. The manager and staff had worked closely with social services. They had taken steps to make improvements and follow recommendations to enhance the quality and safety of the service. We found that Beech Lodge was providing a safe service and that people received support in line with their needs and preferences.

Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Risks to people's safety were assessed, documented and reviewed. The manager had overseen a review of people's risk assessments, specifically in relation to moving and handling. The support people needed was clearly documented and included photographs of the equipment in use. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. People received their medicines safely and at the right time.

There were enough staff to meet people's needs. Staff had received training and were supported in their professional development through regular supervision. The provider had a training academy and the manager encouraged staff to attend training to improve their knowledge, specifically around learning disabilities and autism. Staff were clear on their roles and responsibilities and were kept up-to-date via handovers and regular staff meetings.

People and/or their representatives were involved in decisions relating to their care and treatment. Staff were skilful in communicating with people. They understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were treated with kindness and respect and appeared relaxed and happy in the company of staff. Staff supported people to participate in activities and took time to understand how they wished to spend their time. There was a varied activity programme which included trips and events outside of the home. The home was recruiting a driver and hoped to quickly resume more frequent outings. A visiting entertainer told us, "The staff here really do care for the residents, they encourage them with the music and join in with them". During our visit people were outside enjoying the gardens and grounds. The design and adaptation of the home, including tracking hoists in each room, provided easy access for people.

Staff were attentive and noticed when people required assistance or reassurance. People were supported to enjoy a variety of food and drink and to maintain good health. Where there were changes in people's needs, prompt action was taken to ensure that they received appropriate support. This often included the involvement of healthcare professionals, such as the GP, Speech and Language Therapist (SALT) or Dietician.

The home was well-led. Staff felt able to approach the manager and to raise any concerns they had. The manager had a system to monitor and review the quality of care delivered and was supported by monthly visits from a representative of the provider. The manager received feedback from people, their relatives, staff and visitors. They took prompt action to address any concerns. Where improvements had been identified, action plans were in place and used effectively.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

Medicines were stored, administered and disposed of safely.

Good

Is the service effective?
The service was effective.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received regular supervision.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Good

Is the service caring?
The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care.

People were treated with dignity and respect.

Good

Is the service responsive?
The service was responsive.

People received personalised care that met their needs.

Staff engaged with people and offered both individual and group activity according to people's interests.

People were able to share their experiences and any concerns were quickly addressed.

Good

Summary of findings

Is the service well-led?

The service was well-led but the manager had not yet applied to register with us.

People and staff felt able to share ideas or concerns with the manager.

The manager took an active role in people's support and worked closely with staff to ensure they were clear on their responsibilities.

The manager used a series of audits and unannounced checks to monitor the delivery of care that people received and ensure that it was of a good standard.

Requires improvement

Beech Lodge

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.

This inspection took place on 6 and 8 July 2015 and was unannounced.

Three inspectors and a specialist advisor in moving and handling undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications received from the manager before the inspection. A notification is information about important events which the service is required to send us by law. We also reviewed the findings of two safeguarding enquiries and the action plan the service had put in place in response to the findings. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. We 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 care records for ten people, medication administration records (MAR) and monitoring records for food, fluid and people's weights. We also looked at five staff files, staff training and supervision records, quality feedback surveys, accident and incident records, activity records, complaints, audits, minutes of meetings and staff rotas.

During our inspection, we spoke with eight people who used the service, one relative, the manager, the deputy manager, three registered nurses, six care staff, three activity coordinators, the chef, two physiotherapists, the home's administrator, three representatives of the provider, a visiting tutor, reflexologist and musician. Following our visit we spoke with the relatives of five people and contacted professionals to ask for their views and experiences. These included three social workers responsible for people's placements, two GPs and a visiting entertainer who had involvement with the service. They consented to share their views in this report.

This was the first inspection of Beech Lodge since there had been a change in the provider's registration in October 2014.

Good

Is the service safe?

Our findings

People felt safe at Beech Lodge. One person responded by smiling when we asked if they felt safe and pointed to 'yes' on their communication board. Staff had undertaken adult safeguarding training within the last year. They were able to speak about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member told us, "We are trained to look out for signs of abuse. If I thought it was going on I would let my manager know". Another staff member said, "The management are very keen that we do training in this and make sure we understand our role". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns in confidence.

We examined three care plans for people where there had been recent safeguarding referrals or concerns. They contained up-to-date and relevant information, and appropriate referrals to outside agencies had been made. For one person this included a physiotherapist assessment and a seating review with an external clinic. As a result, adjustments were made to the wheelchair supports which could have explained the redness staff had noticed on the person's skin. In response to two safeguarding enquiries the service had taken action including a full review of risk assessments and care plans in relation to moving and handling, refresher training for all staff and the introduction of specific osteoporosis management care plans. One staff member said, "The training is more strict and detailed now. The physios have taken individual slings for review. They all (people using the service) have photos in their rooms for every procedure". During our visit we observed two people being supported by staff to transfer using a hoist. The transfers were carried out safely. A GP who visited the service told us, 'When I see residents needing to be hoisted onto their beds for extensive medical examinations they seem to be hoisted with care and safety being paramount. The knowledge and skills of the nursing staff normally seems excellent'.

Risks to people's health and safety were assessed prior to admission and were regularly reviewed. A wide range of risk assessments were in place including for moving and handling, people's positioning in chairs or in bed, use of the hydrotherapy pool, going out in hot weather, community access and the use of transport. The risk assessments were detailed and included photos to add clarity, such as on how a person should be positioned in bed when eating to minimise the risk of choking. Staff were able to describe the steps in place to mitigate known risks and explained how they supported people safely. Where possible, people were involved in completing the risk assessments and some had signed them to demonstrate their agreement. A GP who had involvement with the service told us, 'We have always found Beech Lodge to be a safe home and if I had a relative who needed such care I would find it an excellent place for them to live'.

During our visit we observed that staff were available and were able to anticipate and respond to people's needs. Staff were present in communal areas throughout the day. One relative and some staff expressed concern over staffing levels and the fact that temporary staff did not know and understand the people living there. They also told us that there had been fewer outings than usual due to the fact the home had a vacancy for a driver. Others spoke positively about the staffing and told us that many of the staff had worked in the home for a long time. The manager explained that four staff members had left employment since April 2015 and that steps were being taken to recruit new staff. A number of interviews for new staff were scheduled the following day. The manager used a tool to calculate and adjust the staffing levels based on people's needs. This included nursing, care, one to one care and activity staff being allocated to each part of the home, with the manager and deputy manager available to step and provide direct support if required. Staffing rotas confirmed the manager had maintained the staffing level, using staff from other homes run by the provider or agency staff to cover vacant shifts. One staff member told us, "There aren't as many staff as there used to be but we work hard to provide good care. The agency and bank staff help a lot and I'm sure things will get better". Another staff member said, "Sometimes staff don't get the breaks they should but the residents come first. I know the management are getting more staff".

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS maintains records of any criminal convictions or where staff have been deemed unsuitable to work in a care setting. Copies of other relevant documentation, including job descriptions,

Good

Is the service safe?

character references, interview records and Home Office Indefinite Leave to Remain certificates were stored in staff files. These checks helped to ensure that new staff were safe to work with adults at risk. Where agency staff were employed, the manager received and reviewed the profiles of potential staff and made a decision based on their training and experience

People received their medicines safely. Medicines were administered by nurses. We observed part of the medicines round during lunchtime. The nurses checked the medication, the dose, frequency, that they were administering it to the correct person and the expiry date. They also provided clear information for people regarding their medicines and administered them in accordance with the instructions from the prescribing GP. Medicines, including controlled drugs (controlled drugs are drugs which are liable to abuse and misuse and are controlled by legislation), were stored safely and accurately recorded. Guidance was available for 'as needed' (PRN) medicines and, when given, staff had noted the reason for administration. We found that PRN guidelines for some discontinued medicines remained in the file. This had the potential to create confusion and the manager took action to remove them. Records for the administration and disposal of medicines were complete and up-to-date.

Good

Is the service effective?

Our findings

People spoke highly of the staff team. One relative told us, "I'm in awe of them". Staff had access to regular training. One said, "I know what I am doing, we have a lot of training". Another told us, "I think training is taken very seriously here". The provider had their own training academy. Staff were required by the provider to attend annual training updates in fire safety, moving and handling, safeguarding, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), infection control and food hygiene. Additional courses, such as in epilepsy or autism, were available and staff were encouraged to pursue diplomas in health and social care. One staff member said, "It's good that the training focuses on the kind of things that affect residents". One staff member was working towards an advanced certificate in supporting people with learning disabilities. Another explained how they were going to train as a nurse, supported by the provider.

In addition to the classroom based training, two of the home's staff were qualified moving and handling trainers. They were available to provide advice and support to staff, whilst also observing their practice as they worked alongside them. One trainer explained to us, "If the nurse feels concerned, I would do a one to one assessment".

New staff attended a five day induction programme. This included the provider's mandatory training and was structured around allowing staff to familiarise themselves with the provider's policies, protocols and working practices. A tutor who was visiting to assess a staff member for their diploma told us, "Staff are knowledgeable on health and safety and on policies and procedures, the induction is good". Following the classroom based induction, staff shadowed more experienced staff until such time as they were confident, and deemed competent, to work alone. When agency staff worked at the home for the first time, they received a short formal induction and were paired with an experienced member of staff during the shift. One staff member told us,

"We get staff come over and help us. I explain to agency as I work with them. It makes things easier for me and for them".

Staff were happy with the formal and informal support they received. One staff member said, "I haven't been able to fit in formal supervision for four months but I'm very happy with the day-to-day support and I think that's what matters". Another staff member said, "I had my supervision session quite recently and it gave me the chance to talk about some training I want to do, as well as talk about the people who live here". Records confirmed staff received supervision with their line managers. Appraisal meetings had not yet taken place but were scheduled to take place within the next six weeks. One staff member told us that they had completed their self-assessment and that their meeting with the manager was booked.

During our visit we observed staff involved people in decisions and respected their choices. One staff member said, "We are always explaining before doing any procedures". Another told us,

"If they are still sleeping we let them sleep and then come back". Staff understood the requirements of the Mental Capacity Act 2005 and put this into practice. For example, staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waited for a response before acting on their wishes. We observed staff asking people if they wanted to spend time outside as it was sunny on the day we visited. Most chose to but others communicated a clear preference to stay inside, which was respected. Some people had expressed a preference to be cared for by female staff. This was documented and daily records confirmed that only female staff had supported them with personal care. One person had decided not to take a particular medicine. The records showed how staff had discussed the risks with the person and how they had communicated through gesture that they did not wish to continue with the treatment. In line with their wishes the GP had discontinued the medicine.

Where people did not have capacity to make particular decisions relating to their care or treatment, the manager had acted in accordance with legal requirements. People's capacity had been assessed to determine whether or not they were able to participate in decision-making. Where this was not possible best interest meetings had been held, involving relevant professionals and relatives to make a decision in the person's best interest on their behalf. Examples included a decision to use an audio monitor in a person's bedroom at night to monitor seizure activity, a decision to fit a gastrostomy tube to ensure that a person's nutritional needs were met and a decision not to resuscitate in the event that a person's heart stopped.

Good

Is the service effective?

The manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'. We saw that applications had been submitted for each person who lived at the home. These included a request to authorise the use of restraints in place for people's safety, such as a lap belt on a wheelchair. The home had received decisions on two applications from the local authority.

People were offered a choice of food and drink and supported in line with their needs. We observed staff supported people to drink during the morning and offered one to one assistance at lunchtime. Information on people's needs and preferences were recorded in their care plans. We read, 'I prefer a hot breakfast such as beans on toast', 'I use hand over hand method to eat with a shaped spoon' and, 'I will let you know if I want more by staring at the empty plate'. On a daily basis, people were asked to choose from the menu, which was available pictorially, and their choice recorded and shared with the kitchen staff. If at the point of service, they changed their mind, alternative meals were available. One staff member told us, "We have to be sure there are lots of options," and explained how one person had chosen to have cereal for dinner the previous day. Where people had specific needs these were provided for, including meals prepared to a variety of textures and in one case an early meal time to allow time for the person's food to settle whilst they were upright before going to bed.

People were monitored and assessed to determine if they were at risk of malnutrition. Staff recorded people's weight on a monthly basis and made referrals for professional advice when concerns were identified. Where necessary, food and fluid charts were used to monitor people's intake. Eating and drinking guidelines were in place for some people, written by a Speech and Language Therapist. Staff were able to explain the support they provided, including on positioning and the use of aids such as plate guards, adapted cutlery or beakers. Some people were unable to eat and drink and received their nutrition via a gastrostomy tube directly into their stomach. The nurses were responsible for this and followed guidance from the dietician to ensure people's nutritional needs were met.

We discussed the hot weather with staff and asked how they ensured people were hydrated. We were told NHS Heatwave alerts and guidance were disseminated by the provider and discussed in staff handovers. Our examination of daily records confirmed this. Staff explained that people were offered extra fluids and particular attention was paid to those who were particularly vulnerable, including those with epilepsy.

People had access to healthcare professionals. The home had two physiotherapists directly employed by the provider. They supported people with exercises, including passive movements, walking, using standing frames and accessing the hydrotherapy pool. Staff shared examples of referrals they had made. This included a referral to occupational therapy for an adapted toilet chair to enable a person to continue to use the toilet and to speech therapy where a person was able to call staff and they felt there was the potential to develop their verbal communication. A GP who visited the service said, 'The staff seem very ready to contact doctors about changes in the health of residents between our weekly visits'. Relatives told us that they were kept informed if there were any changes or concerns in their relative's health. One said, "They ring me when she sees the GP or has a fit. I've had no worries whatsoever".

The home was purpose built by the provider. Each room was equipped with an overhead tracking hoist. There were assisted, height adjustable baths, hydrotherapy pools (one of which was closed for repairs) and a sensory room, each equipped with overhead tracking hoists. The manager described her plans to develop the sensory features in the home and garden. For the garden, this included a water feature and plants of bright colours, strong fragrance or that were soft to the touch. People had personalised their bedrooms according to their taste. During our visit people were outside enjoying the garden, which was accessible, including a pathway to allow those in wheelchairs to enjoy the grounds. The adaptation and design of the home meant that people were able to move freely and access its facilities.

Good

Is the service caring?

Our findings

People appeared happy and at ease in the company of staff. We observed staff supporting people to participate in activities and chatting with them about things that were important to them, such as forthcoming events and holidays or remarking on how well vegetables they planted were growing. One social worker told us, 'My experience with the placement was positive; I was able to observe the interaction with the staff and the young person I was reviewing and could see that from his response of smiles and making sounds as way of responding to the staff communicating with him that he was happy'. One relative said, "I know (person) would let me know if he wasn't happy. He comes home and is always eager to go back". Another told us, "They also joke with him. You can get (person) to laugh a lot and they're able to do that"

Staff supported people to maintain relationships with people who were important to them. Relatives told us how the home had suggested and arranged transport for them to visit their relative living at Beech Lodge or provided transport for their relative to meet them in a local town. During our visit one person became anxious as they wanted to spend more time with a friend who lived at another service run by the provider. We observed as a staff member discussed how they were feeling and offered solutions, such as inviting their friend to lunch at Beech Lodge.

Staff were skilful in communicating with people and understanding their wishes. Many of the people living at Beech Lodge had limited or no verbal communication. Staff explained to us, "If he says "sore", it means he wants a massage" and, "If (person) is hungry or thirsty they use a kind of Makaton" whilst demonstrating the actions. Another told us, "You spend time with them one to one and you get to know them". We observed staff involving people in activities and waiting for their responses, such as on the fabric they wished to use in a craft activity. People's care plans included detailed assessments of their verbal and non-verbal communication. These were used to identify physical and verbal cues to understand when a person was happy or was starting to become distressed. The assessments described the action staff needed to take in order to support and reassure the person. In one person's records we read, 'When I make distinctively strange sounds or actions like making faces or putting a fist on my cheek, it means I am anxious or stressed. Please reassure me and explain things clearly'. A visiting entertainer shared how a particular staff member, 'Has a good relationship with the residents and knows a great deal about them. She is gentle and attentive; she can always make contact with each of them'.

Most people had communication passports. These provided a summary for visitors or visiting professionals on how to communicate with the person. We found that these did not always reflect the guidance available in people's care plans. Furthermore, they were usually attached to the back of people's wheelchairs which made it difficult to access them without standing close behind or to the side of the person. The manager told us that she would update the communication passports to ensure that they were effective in promoting people's communication with visitors.

People were involved in decisions relating to their care. We observed people were asked where and how they would like to spend their time, what they wished to eat and drink and where they wished to entertain their visitors. People's preferences with regard to clothing and personal care, such as if they preferred to shower rather than bath, and the specific toiletries they used were documented. One staff member told us, "Sometimes we go through his whole wardrobe to choose a top or pair of socks". Monthly resident meetings were held and used to discuss and plan forthcoming activities. We saw people had chosen the theme for the summer barbeque with families. The manager had introduced a keyworker system. She explained that this would mean each person had a one to one meeting with a staff member assigned to them as a keyworker to review their support and discuss any concerns or new ideas. One relative who was legally appointed to represent one of the people who lived at the home told us, "I always feel that they will help to make a decision, they are willing to talk to me about things".

All of the people we spoke with told us that they were treated with respect. People were called by their preferred names and staff involved them in decisions that affected them. A visiting tutor told us that in their experience staff were, "Very polite and supportive". We observed staff were respectful and considerate. They made sure people's privacy was maintained and were discreet in assisting them to leave communal areas in order to support them with personal care needs.

Good

Is the service responsive?

Our findings

Staff knew people well and understood how they liked to be supported. Each person had a named nurse and a keyworker. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. People's choices and preferences were documented in their care plans and the daily records showed that these were taken into account when people received care. One of the nurses told us, "We are attentive to them, we know what they need. If their face is not happy we really know that". A social worker who had carried out a review said, 'Staff were able to explain the young person's needs and how they supported him to meet his needs; they had care plans for all tasks they supported him with'. Relatives spoke positively about the support provided. One said,

"He responds to them well and they know when he is not happy, definitely. They seem to be on the ball with his needs". Another told us staff understood their relative's needs in relation to autism. They said, "You've got to comply with the routine. Beech Lodge recognise that and that's a really important thing. Not many people understand autism".

Where risks had been identified such as epilepsy, wounds or behaviour that could be described as challenging, monitoring was in place. This helped ensure appropriate action was taken to support people and to respond to changes in their needs. When staff noted changes in one person's behaviour a multi-disciplinary behavioural assessment meeting was held. As a result new strategies were put in place and the care plan was updated with additional detail on how to assess and manage the person's pain. A relative described how staff had noticed an ear infection in their relative. They said, "A lot of staff know his behaviour and make enquiries". The manager had introduced new processes to manage wound care. This included a wound care photograph diary. The records were complete and demonstrated a clear management plan to promote healing and ensure the person's pain was minimised. During our visit we observed staff took prompt action to relive people's distress or discomfort, such as by supporting them to adjust their seating position, or positioning them so they could communicate with friends. A visiting entertainer told us, "People get a very good standard of care; people are not left, when they signal for support, staff act". One relative told us, "They monitor if anything unusual comes up. They always let me know if he isn't well".

Staff were kept up to date with any changes in people's needs. The manager had introduced a more detailed handover whereby the full day's care and activity was shared with the new shift. This included comments from nurses and any visiting healthcare professionals. A weekly meeting between the manager and nursing staff was held following the GP visit to ensure that any changes were communicated effectively and that staff could respond to people's needs.

During our visit people were involved in activities, including crafts, drama and entertainment from a visiting musician. Each person had an activity programme for the week. A sample of activities included attendance at day centres run by the provider, swimming, drama, trips to town, live entertainment, cookery, gardening and use of the IT facilities. Individual activity records showed people were involved in a range of activities and outings. We saw that there had been fewer outings in recent weeks. Staff explained that this was because there was a vacancy for a driver but they were looking forward to resuming regular outings. Trips this year to-date included lunch out, shopping, cinema, church, pottery, supermarket visits, concerts and theatre. The activity coordinator told us, "Trips have always been important to us". One visiting therapist told us, 'They are also supported in visiting friends or partners who live in other homes. Residents' birthdays are big occasions, there is always a few weeks preparation before Easter, Christmas, Mother's Day, Father's Day etc., and the residents are actively involved'. A relative who visited regularly said, "They do a lot of activities".

People and relatives were encouraged to share their thoughts and ideas with staff. The manager explained that since they had joined in October 2014, they had not held a formal relatives' meeting. Most relatives felt they had good communication with the home. One said, "We are really happy with it. Whenever there is a slight glitch they always ring me to talk through the issues". Some mentioned the lack of meetings but said they were due to attend the summer barbeque event which, along with the Christmas party served as a formal opportunity for relatives to meet with the staff and manager. A suggestions box was available in reception which provided an opportunity for

Good

Is the service responsive?

those who preferred to make comments or raise concerns anonymously. The provider sent feedback questionnaires to relatives and responded to any comments that were made, where appropriate offering a meeting for further discussion.

The provider had a complaints policy which was clearly displayed in the home. We saw that the two complaints received had been dealt with appropriately and in accordance with the timescales set out in the policy.

Requires improvement

Is the service well-led?

Our findings

The service is required by a condition of its registration to have a registered manager. At this visit we found that a new manager was appointed in October 2014 but had not yet made an application to register with us. The person registered to manage the service had not worked at the home for over a year. The provider had not ensured that a new manager applied to register with us within a reasonable timescale.

There was a happy atmosphere in the service. Staff spoke positively about their roles. One said, "We've got good teamwork. You always walk out with a smile at the end of the shift". The manager explained that the ethos they wished to engender was, "Nursing care within a homely environment". They explained how they would encourage staff to complete advanced training in learning disabilities and how they encouraged staff to spend social time talking to people. They also explained how they had made contact with local students to try and set up a befriending programme for those people who were interested. One relative told us, "The atmosphere is great, we get offered tea and coffee as soon as we arrive". Another said, "Each time I go there I feel that I couldn't have done any better for her".

Staff felt able to share any concerns they had with the manager. One told us, "We can speak up". They explained the action they would take if they noticed any errors, such as gaps in the medication records. One of the nurses described how they monitored the care being given to people and how they addressed poor standards with individual staff members if observed. Staff were aware of the new legislation relating to duty of candour. One described it as, "We have to tell the truth and share what we investigate with the family". The provider had a policy in place dated March 2015.

People, staff and relatives spoke positively about the manager. One staff member said, "(The manager) is bringing new ideas". A visiting professional told us, "(The manager) has the get up and go but also a gentle, caring side to her". They also said, "The manager has shaken the home up in a good way, she is very approachable. It's a lovely home". Staff confirmed that the manager joined the morning handover meetings and was regularly involved with people and activities taking place in the home. A visiting entertainer said, "The manager is very hands-on and encouraging. It's a nice place to come". We saw in staff meeting minutes that staff were encouraged to come forward if they needed clarification or guidance and that the manager had reiterated that they were available and ready to assist.

Staff shared examples of changes that had taken place. One said, "There have been positive changes, the full allocation is done at handover now, everyone knows what they are going to do for the whole day. It is working more smoothly". We saw that action had been taken in response to recent safeguarding enquiries to make improvements to the service and that other recommendations, such as from the fire service, had been implemented. Where we noticed issues during our inspection, such as a meal not being served at the correct temperature, the manager took immediate action to address this with staff. The manager was supported by a representative of the provider who was present during our visit. Staff representatives attended provider level meetings including for infection control leads and at an employee forum. This helped to ensure that knowledge was shared amongst the staff team. The manager had introduced short quizzes to test staff knowledge at staff meetings, such as on the Mental Capacity Act, commonly used acronyms or changes in legislation including the introduction of the regulation on duty of candour.

The manager had tools to monitor and improve the quality of the service people received. These audits and reports fed into the provider's governance system. A weekly report involving an inspection of the premises, a summary of any accidents or incidents, complaints and an overview of staffing, including agency usage was compiled and sent to the provider. There were monthly audits of accidents and incidents, medicines and hoist slings and an audit of care plans had been completed in March 2015. Where areas for improvement were noted, such as in dating boxed or liquid medicines on opening, this was documented and followed up with staff. New slings had been purchased to ensure people had the most appropriate model for their needs and that they were in good condition. Maintenance checks on equipment such as hoists were up-to-date and the next check was clearly marked on each item. A representative of the provider carried out monthly audits. These included action plans which were reviewed at the next visit. There

Requires improvement

Is the service well-led?

was evidence of actions being followed through, for example photographs of slings had been included in people's care plans and staff had attended refresher training in moving and handling.

The provider commissioned external audits of their service. An independent auditor had completed reviews in October 2014 and July 2015 and a specific health and safety audit had taken place. Between October 2014 and June 2015 the service had made significant improvements to health and safety. This was reflected in the improved score in the company's rating scale. We read, 'Efforts in achieving a 14% increase in the overall score is a credit to the hard work and teamwork of all staff involved at the site'. We found that there was an effective system to review the quality of the service, to set improvements and to monitor progress.