Short Ground Limited

Norcott Lodge

Inspection report

Norcott Lodge
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West Yorkshire
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Tel: 01924408505

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 April 2016 and was unannounced. This was the first inspection of Norcott Lodge.

Norcott Lodge is registered to provide personal care and accommodation for up to nine people. There are seven en-suite bedrooms with shared access to kitchen, dining and lounge areas, as well as two self-contained flats with their own kitchen, dining and lounge areas. This means people have the opportunity to live within small, personalised accommodation but with the support of staff. There were nine people living at the home at the time of the inspection.

The previous registered manager for the home had been promoted within the company and there was a new manager, who had been in post for two weeks. The new manager advised they would be applying to become the registered manager. 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.

People and their relatives told us they felt safe living at Norcott Lodge. Staff were able to recognise potential signs of abuse and had received safeguarding training so they understood the appropriate policies and procedures in order to help keep people safe.

Staff were recruited safely and trained appropriately. There were enough staff to meet people's needs. Staff were offered opportunities for self-development.

Medicines were stored and administered safely and appropriately and staff who were responsible for administering medicines had been trained to do so.

Staff received a thorough induction and ongoing training to ensure they were able to provide effective support to people. Staff were supported in their roles.

Where people lacked capacity to make specific decisions, a mental capacity assessment had been undertaken and decisions were made in people's best interest, in accordance with the principles of the Mental Capacity Act 2005.

People were encouraged and supported to maintain a healthy lifestyle, for example through healthy eating.

Staff knew people well and people's privacy and dignity were respected. People's cultural and religious needs were considered and respected. Staff were caring in their approach and there was a positive atmosphere in the home.

Care and support was provided to people in a personalised way and this was reviewed regularly. People were involved in developing and reviewing their care and support.

People were enabled to develop life skills and to become more independent through work, education and training. People were encouraged to develop and achieve their goals.

Regular checks and audits took place to try to continually improve the home. The manager, although new in post, had held meetings with staff and with people who lived at the home, with a view to assessing and improving quality and there was a history of good engagement with people and their relatives.

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.

Staff were trained and developed in order to follow current practices and guidelines in relation to safeguarding adults.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

The environment and premises were well managed and appropriate checks took place to ensure people's safety.

Is the service effective?

Good

The service was effective.

Staff knew the people who they were supporting well and this enabled effective support to be provided.

Staff had received training to enable them to provide effective care and support to people.

The requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were met and staff were able to demonstrate they understood the principles.

Is the service caring?

Good

The service was caring.

There were positive interactions between staff and people.

People's privacy and dignity was respected.

Staff were aware of specific communication needs of different people and were able to respond appropriately.

People's religious and cultural needs were respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's preferences and choices, and plans were tailored to each individual. This enabled personalised care to be provided by staff.

Care and support was reviewed regularly.

People were involved in a range of activities, employment and education.

Is the service well-led?

Good

The service was well led.

Staff felt supported by the manager and registered provider.

Robust auditing systems were in place to monitor and improve quality of service.

The culture of the home was open and transparent.

Norcott 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.

The inspection took place on 12 April 2016 and was unannounced.

The inspection was carried out by an adult social care inspector. Before the inspection, we reviewed the information we held about the home and contacted the local authority. The registered provider had been asked to complete 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. This information was used to help plan our inspection and consider our judgements.

We used a number of different methods to help us to understand the experiences of people who lived at the home including observations and speaking with people. We spoke with three members of care and support staff, the manager, two people who lived at the home and four relatives of people who lived at the home.

We looked at four people's care records, three staff files and training data as well as records relating to the management of the service. We looked around the home and saw people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

A relative we spoke with told us they felt their family member was safe living at Norcott Lodge and said, "It's safe and it's managed very well."

The manager was clear about safeguarding reporting procedures and was able to outline different types of abuse and the potential signs to look for, which may indicate if someone was at risk of harm or abuse. Staff we spoke with also understood how to identify signs of possible abuse and the procedures to follow if they had any concerns. Staff understood the importance of this when supporting people with complex needs. There was a safeguarding policy and whistleblowing policy in place and staff were aware of these. Staff we spoke with told us they would not hesitate to report any poor practice. This helped to protect people because staff were aware of what safeguarding was and what action they could take if they suspected anyone was at risk of harm.

Risks were managed by assessing potential hazards and putting measures in place to minimise these, whilst also trying to ensure people maintained their independence. Information included in risk assessments related to the level of risk, the negative impact of the risk, the benefits to the person of reducing the risk and the action taken to reduce the risk. Personalised risk assessments were in place in relation to physical aggression, self harming, bathing and showering and road safety, for example. These were specific to the individual. Having risk assessments in place helped to ensure that people were encouraged to be as independent as possible whilst any associated risks were minimised.

Appropriate health and safety and building maintenance checks took place. For example, portable appliance testing (PAT) had taken place to help ensure electrical appliances were safe. Gas safety checks had been completed. Regular water temperature testing had taken place and action was taken to reduce the temperature if this was found to be outside recommended safe limits. This meant steps had been taken to ensure the premises and equipment were safe.

A fire safety inspection had taken place during January 2016, which recommended a fire risk assessment be completed and escape routes, escape signs and fire door availability be considered. We saw this had been actioned and reviewed. A fire risk assessment had been undertaken and reviewed and environmental risk assessments had been completed in relation to staircases and trip hazards.

Fire evacuation procedures were displayed around the home and these were also in a pictorial format which helped people to understand what actions to take in the event of a fire or emergency situation. We saw people had personal emergency evacuation plans in place which detailed the action to take and the level of support each person would require in an emergency. This helped to ensure people's safety in the home, in the event of a fire or emergency evacuation.

We observed a staff emergency alarm was activated during the inspection. Staff and the manager responded immediately but calmly to this. Although the alarm was activated inadvertently and there was no emergency, this showed the system worked effectively and staff and the manager responded appropriately

to keep staff and people safe.

Records were kept of accidents and incidents. We could see that appropriate action had been taken following incidents and any learning was shared through staff meetings. We saw that, where accidents or incidents had occurred, correct procedures had been followed in terms of reporting to safeguarding and to the Care Quality Commission.

The manager told us staffing levels varied, depending on the activities people were undertaking. There was a minimum of 12 staff during the morning and 11 staff during the afternoon, to provide support for up to nine people. People living at Norcott Lodge were asked, on a weekend, what their preferred activities would be the following week, and staff rotas and levels were then planned accordingly. The staff we spoke with told us they felt there were enough staff. The family members we spoke with also told us they felt there were enough staff to support people living at Norcott Lodge.

We looked at three staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed from two referees and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were stored and administered. Medicines were stored safely and securely. Temperature checks took place twice a day to ensure medicines were being stored at the correct temperature.

Each person's record in relation to their medicine contained a photograph of the person. This reduced the risk of medicine being administered to the wrong person. The person's record also detailed how the person liked to take their medicine. We saw one person's record stated staff should count aloud to 10 when the person was using medicated mouthwash, before spitting the mouthwash out. We observed the staff member followed the instructions and did this in practice. The staff member washed their hands and wore protective gloves prior to administering medicine.

We looked at the medication administration records (MARs). The staff member administering the medicine ensured they signed the record once the medicine had been administered. If anyone refused their medicine, this was clearly recorded and a record of this was kept so unused medicines could be returned and this information could be shared with relevant professionals. We checked a sample of medicines and the numbers remaining reconciled with the records.

As well as the MARs, staff had access to a medication profile folder. This contained further detailed information relating to people's medicines such as the purpose, side effects, effect if not taken and overdose implications. This gave staff a further understanding of different medicines.

Some people had been prescribed PRN medicine (to be taken as and when required). The effect of this was sometimes to modify behaviour. We saw guidelines for the use of this medicine, including when it should be given and the potential side effects. A monitoring form was in use to prompt staff to think about why they were administering the medicine. The monitoring form impelled staff to consider alternatives and to log how often this was used and the resulting changes in people's behaviour. The form made clear this medicine should 'only be used as a last resort.' Additionally, this needed to be approved by a manager. The medication policy stated, 'behavioural modifying medication must never be administered as an unnecessary restraint'. The procedures in place ensured this policy was followed. Furthermore, we saw in one of the care plans we sampled, the plan stated the use of PRN medication must be authorised by a

Norcott Lodge manager. This demonstrated that people were not inappropriately restrained by use of medication.

Some people who lived at Norcott Lodge had behaviour which other people could find challenging. In order to manage this, the service sometimes used restraining techniques. We saw staff had received appropriate training in the safe use of restraint. Staff told us they would try de-escalation techniques and use restraint as a last resort and this was clearly documented in care plans, with examples so staff were aware of how to verbally redirect people. Plans included information relating to the signs to look for which may indicate a person's behaviour may become challenging and the action staff should take. This helped to ensure that people, and those around them, were kept safe.

We found the home to be clean and fresh and observed good infection control practice. We overheard a support worker remind a person of the importance of washing their hands. This showed staff were aware of the importance of personal hygiene and they encouraged people to follow good infection control practice.

Good

Is the service effective?

Our findings

A family member told us they were happy with staff and their knowledge but also added that staff turnover seemed to be high.

Another relative we spoke with said, "We love it and [name] likes it. They support [name] with everything."

A member of staff told us that new staff had one day of induction at the service and then 10 days training, off site, in areas such as first aid, moving and handling, food hygiene and safeguarding. They then returned to the home for a second day of induction and were given the opportunity to read care plans and meet people. Staff then spent a week shadowing a more experienced member of staff and a buddying system was in place to support new members of staff. We saw evidence of this thorough induction in the staff files we viewed. A new member of staff we spoke with told us they felt the induction had prepared them well for their role. This helped to ensure new staff developed the necessary skills and were given the support required to perform their role effectively.

Established members of staff had completed the Skills for Care common induction standards and new staff were working towards the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Skills for Care induction is designed to provide a structured start for new employees to help ensure they are safely able to provide support to people. This helped to ensure staff had up to date skills to enable them to provide effective care and support to people.

The service offered staff opportunities for self-development. There was a training system in place which encouraged staff to increase and improve their skills and knowledge through internal promotion. One of the staff members we spoke with had applied for, and been successful in gaining, more senior positions within the home through these training and development opportunities. Staff had received training in areas such as safeguarding, moving and handling, management of actual and potential aggression, first aid, mental health, autism, and epilepsy. A staff member told us, "All I have to do is ask if I want more training." This further demonstrated to us staff had received training to enable them to provide appropriate support and help keep people safe.

The manager told us they aimed to provide staff with one to one supervision every three months. We saw a supervision matrix had been devised and this helped to ensure staff received regular supervision. Staff told us they felt supported in their role.

Staff communicated effectively with people. Care plans contained clear information to staff on how to effectively communicate. For example, one care plan we sampled stated, 'Do not try and pass off what [name] is saying because it is difficult to understand. Ask [name] what letter the word begins with and provide a notebook and pen.' When we spoke with this person, staff encouraged the person to write down what they wanted to communicate. This showed people received appropriate support from staff to enable them to communicate effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff we spoke with understood the principles of the Mental Capacity Act 2005. Care plans made it clear that people could make their own choices. For example, one plan stated, '[Name] has capacity to understand implications of an unhealthy diet but still chooses to eat unhealthy food. This is [name]'s choice, however staff have a duty of care to advise and recommend better choices and encourage to only eat unhealthy foods on special occasions.' This showed that staff were aware of people's rights to make their own choices. We observed staff encouraging this person to eat healthily.

We saw mental capacity assessments had been completed and were decision specific, for example in relation to the level of support a person required, where the person should live and whether a person required assistance to take their medicines. Where appropriate, decisions had been made in people's best interest and least restrictive options had been considered. This helped to ensure people's human rights were protected.

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). Appropriate authorisation had been sought and granted by the local authority which meant people were not deprived of their liberty unlawfully.

The manager told us meals and menu planning were discussed at resident meetings and we saw evidence of this. Some people received support to cook their own meals and this varied, depending on what people wanted to do. We saw healthy food options were available, such as a variety of fruit and we saw fresh produce was used to prepare meals.

People were encouraged to maintain a healthy diet. One of the care plans we sampled stated, '[name] likes pizza and fast food. [Name] finds it difficult to regulate own food intake. Should be encouraged to snack on low fat alternatives.' We saw this person was eating an apple whilst we spoke with them.

We looked at the layout and design of the home. There were photographs on display and people's achievements were displayed. Areas inside the home were kept clean and tidy. There was access to gardens and outside space which were well maintained.

Good

Is the service caring?

Our findings

One person we spoke with told us staff were kind. Another person told us they liked living at Norcott Lodge.

A family member said, "Staff are caring. Some are over-caring and they worry about [name of person]." This family member also said, "[Name of person]'s really comfortable with staff."

Another relative told us, "Staff are really nice. We can visit whenever we want. They ask us if we want anything. Staff are very caring. They're more like befrienders." This relative also told us staff were very respectful of their family member's religious views and needs.

We were told by a family member that staff were enthusiastic about the activities they pursued with their relative and they felt their relative was happy. This family member said, "You would see in [name]'s behaviour if [name] was not happy."

Norcott Lodge was a multi-faith home. The home supported and enabled people to practice their chosen faith. For example, one person was supported to purchase a particular food that was pertinent to their religion. Another person was supported to pray and this person was attending a religious festival at a local place of worship the day after the inspection. This person told us this was important to them.

People's privacy was respected. We observed one person's door had a notice displayed stating, 'Knock and wait for response.'

Confidentiality was valued. Each care plan contained a notice in the front stating anyone wishing to access the information in the file must contact the home manager. This helped to ensure that personal information was kept private and confidential.

When we asked a staff member how they ensured people's dignity was maintained, if they were assisting someone with personal care, for example, the member of staff said, "I ask people what they want. I use a big towel to wrap around them if they are compromised in any way." This member of staff told us they would ensure curtains and doors were closed. A care plan we sampled stated, 'Prompt [name of person] to close their blinds/curtains prior to personal care to prompt privacy and dignity.' This showed the person's privacy and dignity were respected as part of the care planning process and staff understood how to respect people's dignity.

We heard staff speak to people with caring tones and genuine interest. For example, the person who was attending a religious festival the day after the inspection was going to be supported to do this. The member of staff supporting the person talked with the person about how important the festival was and what their plans were for the day. The person being supported was frequently asking questions about the plans for the day and the member of staff patiently explained the arrangements repeatedly. This demonstrated the staff member had a caring manner and was patient and understanding.

A member of staff told us, "Because you're here every day, you can tell whether people are happy or not. I want people to be happy." This staff member told us they had asked for specific training to assist people going through bereavement and this was provided. This meant the staff member was able to offer support to people who had been bereaved.

We observed staff interacting with people and saw people appeared comfortable in staff presence. Appropriate use of eye contact and touch was used, but staff also gave people the time and space they needed.

Two people living at Norcott Lodge had received support from an advocate. An advocate is a person who is able to speak on other people's behalf when they may not be able to do, or may need assistance in doing so, for themselves.

Good

Is the service responsive?

Our findings

A family member told us, "They [staff] keep in touch and let me know if there are any problems. [Name] is getting a lot more occupation and activity than they did in their previous living arrangements [prior to living at Norcott Lodge]." This family member told us staff listened to the views of their relative.

A person we spoke with told us they had been to Blackpool and they were looking forward to going again. Another person had visited the set of a television programme they liked to watch.

A relative we spoke with told us they were involved regularly in reviewing their family member's care plan. This family member also told us they had received questionnaires, asking for their views about the service.

Care and support plans were personalised to each individual. Each plan we sampled contained a photograph of the person at the front of the file along with key information, including important medical information. The plans we sampled were up to date and had been evaluated during March 2016. Plans contained information such as the support the person required in relation to dressing, personal care, weight, nutrition and eating and sleep for example. Plans were detailed and contained relevant information. For example one plan stated, 'May express thoughts through role play. Repeat what [name] is saying by saying it back to [name]. Ask [name] to write it down.' We observed staff interacting with this person and they communicated with the person well and in accordance with the care plan to good effect.

We saw care plans contained important information relating to how a person may communicate purposeful phrases. This was indicated through a communication assessment tool, which stated the sounds, facial expressions, words and gestures a person may make in order to communicate specific feelings. This helped to ensure staff could understand people's needs in order to provide effective support.

People's choices and preferences were indicated in their care plans. For example, one plan we viewed stated, 'Should have access to free flowing water but on occasions chooses to bathe twice per day. Will indicate to those supporting when [name] wishes to bathe.' Another plan contained detail such as, 'Likes bread cut into four pieces.' The staff we spoke with told us people made their own choices about their daily routines and the activities they wished to undertake. This showed people were able to make their own choices and staff were given appropriate information in order to provide personalised care and support to people.

People were involved in their care planning. Care plans were reviewed monthly and staff signed to indicate they had read the care plan. Key worker catch ups were held monthly and these meetings provided the opportunity for people to raise any issues with their key worker and to consider their future goals and care planning.

Each person had a health file. This contained important information regarding the person's health, such as records of conversations with general practitioners, pharmacists and family. If actions were required, these were recorded and logged when completed. Personalised health information was contained within the file,

which was shared with other health professionals, to ensure continuity of care, for example in relation to the person's communication needs, choking risks, level of understanding and 'When I am unwell, this is what I am like.' This helped to ensure people received consistent person centred care when they moved between different services.

As well as care plans, each person had a person centred plan (PCP) which they had contributed towards. These plans contained many photographs of the person participating in activities they enjoyed and records of achievements. The PCP contained information such as, 'What is my goal?' and 'What am I working towards?' Consideration was then given to who could help the person achieve their goal, what the person was good at, what support the person may need and what other people admired about the person, for example. These plans were thoroughly completed and helped people to plan and achieve their goals.

Each person was allocated a key worker in the home. People discussed their goals with their key worker and produced a 'my life, my goal' document which detailed what the person was hoping to achieve. The person was then supported to achieve their goals. An award ceremony was held at a community venue where people received recognition for their achievements. A member of staff we spoke with told us the goals needed to be achievable and recognised the positive impact that achieving goals could have on a person. This empowered people and helped people to live fulfilling lives.

Daily notes were completed by support staff and contained important information such as each person's mood, activities, personal care undertaken and medication information. This information was shared between staff when shifts changed. Furthermore, staff shared information, in a written format, about tasks that needed completing such as health and safety checks. This helped to ensure continuity of care and support.

People participated in a range of activities such as social clubs, dining out, education programmes, shopping, exercises, meal preparation, arts, crafts and textiles and swimming. Furthermore, people were enabled to develop life skills and to become more independent through work, education and training. For example, some people received support to enable them to work in the local community or attend education projects including maths and English.

The manager told us family and friends could visit the home any time and the family members we spoke with following our inspection confirmed this. This showed people were encouraged and supported to maintain relationships with people who were important to them.

We saw people had their own important items displayed in their rooms, such as religious symbols, reward charts, medals and certificates of achievement. We saw in some people's bedrooms labels had been devised to assist people with their laundry and selecting clothes. For example, each drawer had a label showing what items should be placed in the drawer.

Whilst we found most people's rooms were personalised to their own taste, we found one person's room was not personalised in any way. The reason for this related to the safety of the person, their possessions and the safety of other people. We raised this with the manager and suggested that alternative means could be considered so the person's room could be personalised to some extent whilst maintaining safety. The manager was receptive to this and agreed to consider this further with the person.

We looked at how complaints were managed. No complaints had been received since the new manager was in post. However, the manager was able to explain how they would respond to complaints. We saw previous complaints, whether written or verbal, were logged and responded to appropriately and action was taken. A

family member we spoke with told us they had no cause for complaint but would feel comfortable in raising any complaints or issues with the manager.

We saw evidence that appropriate referrals were made to other professionals and agencies where appropriate. For example, one person was displaying heightened behaviour due to some recent changes in their family and a referral was made to a psychiatrist and community nurse for additional support. This showed people received additional support when required to meet their needs or if their needs changed.

Good

Is the service well-led?

Our findings

The previous registered manager for the home had been promoted within the company and there was a new manager, who had been in post for two weeks. The new manager advised they would be applying to become registered manager.

The new manager had spent a week working alongside the previous registered manager and had considered the priorities for the home such as people's needs, safeguarding procedures and reviews. At the time of the inspection the manager was continuing to receive support from the previous registered manager, who was also present at the home on the day of the inspection.

A family member we spoke with told us the new manager had introduced themselves to the family and they were happy with the new management.

A member of staff said, of the new manager, "People have taken to [Name of manager] very well." We were told by the staff member that the manager, 'spends a lot of time on the units and talks to people.'

A staff member said, "I enjoy coming to work," and, "I feel supported by management here."

Another member of staff said, "I think this company is great. People have a good quality of life. I love working here and feel 100% supported in everything I do."

The manager told us they felt staff were keen to provide good, effective care and that staff communicated well with each other in order to do this.

All the staff we spoke with told us they felt supported. Staff had free access to counselling sessions and a member of staff told us they had found these useful during a stressful time in their life. This showed staff received support. Another member of staff we spoke with told us they had always been able to speak with the manager of the home if they had any issues. This staff member told us they felt valued by the manager.

Staff received support and recognition for their work. There were clear career development opportunities for staff who were able, willing and prepared to undertaken additional training. A staff member told us they had received a letter from the registered provider to their home address, recognising their work and contribution. This helped to boost staff morale and showed the registered provider invested in staff.

Posters were clearly displayed in areas of the home, stating the company valued 'openness'. Whistleblowing information and hotline telephone numbers were displayed, to encourage staff to report any poor practice.

The manager told us regular audits took place, for example, in relation to finances, health and safety, care plans, medicines, property and the environment. A medication audit took place weekly with any remedial action logged. We saw regular thorough audits of the home took place by a clinical services manager and actions resulted from these. This showed the registered provider had systems in place for regular audits to

enable them to monitor and improve the safety and quality of service.

Resident meetings were held monthly and this encouraged people to be involved in the running of the home. We looked at minutes from recent meetings and saw actions were completed from previous meetings. People were encouraged to voice their ideas for food and menu planning. Health and safety issues and activities were also discussed. We noted the minutes from March 2016 stated, 'The healthy eating menus are proving to be a huge success.'

A record of compliments included comments from a psychologist, stating how useful the behaviour analysis records were and they exceeded the expectation for residential services. A comment from another health professional commented how well staff had engaged and contributed at a recent sensory training course.

We looked at records from staff meetings. We saw these had been held monthly. Items discussed included health and safety, safeguarding, finances, staffing and activities. In some of the minutes we sampled, we saw discussions had taken place regarding any changes to care plans. Staff meetings are an important part of the manager's responsibility in monitoring the service and coming to an informed view regarding the standard of care and treatment for people living at the home.

The home had appropriate policies and procedures in place, for example in relation to fire safety, hazardous substances, infection prevention and control, moving and handling, safeguarding, whistleblowing and medication.

The vision of the service was displayed throughout the home and this placed value on the importance of self-development. We saw evidence this vision was embedded in practice, by the way that staff were invested in, through recognition and development. The manager told us they felt it was important to maintain staff morale and job satisfaction in order to provide safe and effective support to people.