Heathcotes Care Limited

Heathcotes (Erdington)

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

Summary of findings

Overall summary

This inspection took place on 18 December 2017 and was an unannounced visit. This was the provider's first inspection at this location since registering with us in November 2016.

Heathcotes (Erdington) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home comprises of one purpose built building which is registered to accommodate up to eight people who require support associated with their learning disabilities. At the time of our inspection, there were five people living at the home. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post at the time of our inspection. '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.'

However, the service had experienced a high turnover of manager's in its first year of service. We found that the current registered manager had been absent from work since registering with us in November 2017 and there was an acting manager in post. This was the fourth manager to work at the service. It was evident from speaking with relatives, staff and visiting professionals that the inconsistent leadership within the service had, at times, had an impact on the quality of the service being provided to people within its first year. Nevertheless, everyone we spoke with without exception, were extremely positive about the influence that the new acting manager had had on the service and acknowledged the improvements that had been made since their arrival as a team leader, prior to taking on the role as an acting manager.

We found that people were protected from the risk of abuse and avoidable harm because safeguarding systems and processes were in place and implemented effectively. People were supported by sufficient numbers of staff who had the knowledge and the skills they required to care for people safely and effectively.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, reviewed and monitored. This ensured that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff, to ensure that care was person-centred and any decisions made in respect of their care and support needs, were done so within their best interests and in accordance with the Mental Capacity Act 2005. Where people were assessed to lack the capacity to consent

to the support they received, the provider had followed key processes to ensure that care was provided in the least restrictive ways possible. Applications had been made and authorisations received to safeguard people against the unlawful deprivation of their liberty, where necessary. People's privacy, dignity and independence were respected at all times.

The premises and equipment were well maintained, clean and had been adapted to ensure people were supported to remain safe within their home environment. Staff were also aware of risks to people when supporting them outside of the home in order to promote people's safety within the community.

People received support from staff to take their prescribed medicines as and when required. Systems and processes were in place to ensure medicines were managed safely and only senior members of staff who had undergone specific training and supervision were permitted to administer medicines within the home.

Staff sought the expertise of specialist services and health and social care professionals to ensure that the care they provided to people was in keeping with legislation and best practice guidelines. This included advice and support specific to learning disabilities, autistic spectrum disorders and any associated symptoms, including behaviours that can be considered challenging. Where incidents had occurred within the home which had amounted to actual or potential harm, such as accidents or incidents whereby a person may have presented with violence or aggression, it was evident that this had been reviewed, analysed and monitored so that lessons could be learned and improvements made.

People were supported to maintain a healthy diet and all health needs were met with the support from staff. It was evident that people had developed positive relationships with staff and there was a friendly, calm, relaxed atmosphere within the home. Staff knew people's likes, dislikes and preferences well and supported them to engage in activities of interest. People lived active and fulfilling lives and were supported to maintain and develop relationships with their relatives and friends. Visitors were always made to feel welcome.

Systems and processes in place to monitor the safety and quality of the service included the involvement of people, relatives and other stakeholders. The provider ensured that information was available in different formats to meet the needs of people and promoted their involvement in providing feedback on the care and support they received. Relatives we spoke with knew how to complain and were confident that any concerns that rose would be dealt with efficiently and effectively under the new management. Staff were complimentary of the leadership and management style of the acting manager; they found them to be supportive and approachable with an 'open-door' policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by enough members of staff, who had been safely recruited, to ensure that they were kept safe and their needs were met.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People received care and support with their consent, where possible and people's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care from staff who had received training and had the knowledge and skills they required to do their job effectively.

People's nutritional needs were assessed and they had food that they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, helpful, friendly and caring.

People received the care they wanted based on their personal preferences, likes and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were encouraged and supported to engage in activities that were meaningful to them. However, the provider recognised that additional staff resources were required to enable people to do things that they enjoyed outside of the home.

People were supported to maintain positive relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A high turn-over of management and inconsistencies within the leadership structure had impacted upon the quality of care provided to people. Whilst improvements had been made in this area, these improvements need to be embedded and sustained in order to be awarded a rating of 'good'.

Staff had not always felt supported within their roles and had some apprehension about the sustainability of recent improvements.

The provider had systems and processes in place to monitor the safety and quality of the service, although some improvements were required.

Heathcotes (Erdington)

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 18 December 2017 and was a routine unannounced inspection. The inspection was facilitated by one inspector. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We looked at the information that we hold about the service prior to visiting the home. This included statutory notifications from the provider that they are required to send to us by law about events that occur at the home, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we spoke or spent time with three of the people who lived at the home. We also attempted contact with people's relatives and managed to speak with one. We spoke with five members of staff including the acting manager, the regional manager, a team leader, an acting team leader and a support worker. Some of the people living at the home had complex care needs and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also made general observations around the home and reviewed the care records of two people to see how their care was planned. We also looked at the medicine administration processes within the home. We reviewed training records for staff and at two staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Good

Is the service safe?

Our findings

Everyone we spoke with was confident that people were protected against the risks of abuse and avoidable harm. A Relative we spoke with told us that they felt assured that people were kept safe living at the home. They said, "I have no concerns at all; I can see that [person] is very comfortable with staff. I was worried about how he would cope initially, it was a big change for him and for us but I know they [staff] look after him and take care of him. I feel reassured that he is there and safe; I can't praise them [staff] enough for what they do for him". Staff we spoke with confirmed that they had received training and knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "Safeguarding is about protecting people and keeping them safe; if there was a change to a person's behaviour, or if I noticed any bruises or if they became withdrawn or if I saw or heard anything untoward, I would report it straight away. They went on to tell us that staff had access to contact numbers for external agencies such as the local authority or CQC if they were concerned that things were not being dealt with effectively by the provider. We saw that people looked relaxed and comfortable in the presence of staff and sought staff company and affection. Records showed that staff had received safeguarding training. The acting manager was also aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that any safeguarding concerns that had been raised had been reported to the relevant agencies and had been investigated thoroughly with appropriate action taken.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, reviewed and monitored. This ensured that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff, to ensure that any risk management and care plans were person-centred and that any decisions made were done so lawfully and in keeping with best practice guidance. Staff we spoke with were familiar with people's individual care needs and any health related risks, such as epilepsy or specialist dietary needs. Staff were able to tell us about the support people required to remain safe both within the home and whilst out in the community. For example, one member of staff told us that some people required support with road safety. They said, "We [staff] have to make sure the front gates are shut before we support people to the car because they are sometimes unaware of the dangers of the road and can think it's a game to run out". Records we looked at showed that the provider had had gates installed to the front of the property specifically in response to one person's road safety risks, prior to them coming to live at the home.

Staff were we spoke with were also able to tell us what action they would take in an emergency situation. One member of staff said, "We care for people with lots of different needs and risks. We know some people are at risk of having seizures and that we need to call for an ambulance straight away unless we have rescue medication in place for them; either way we would follow people's individual protocols". Records we looked at corresponded with the information staff told us about people's risks. Risk assessments and care plans were accurate, complete, legible and regularly reviewed and updated to ensure that staff had all of the information they needed to support people to stay safe.

We found that some people presented with behaviours that staff found challenging to manage at times, such as violence and aggression. Information we received from visiting professionals and staff we spoke with told us that initially, they did not always feel well equipped to deal with these situations. However, since the acting manager had joined the service (originally in the role of a team leader), more emphasis had been placed on engaging people in meaningful activities and promoting daily purpose and routine within the home. We were told that this increased activity schedule had significantly reduced the frequency and level of 'challenging behaviour' within the home, in keeping with the NICE Quality Standards. Quality standards set for the care of people with learning disabilities states that very high rates of behaviour that challenges have been reported in services that typically offer relatively limited activities. Ensuring that people with a learning disability have planned, personalised daily activities will help to reduce rates of behaviour that challenges. This would also enhance quality of life and well-being. Furthermore, staff we spoke with told us that they felt better skilled and supported now if/when these situations did occur and that de-briefing sessions had helped them to look at alternative ways as a team to either mitigate or better manage the risks of these situations re-occurring in the future. Records we looked at showed that incidents of 'challenging behaviour' were analysed and risk management/care plans were reviewed and updated accordingly with new ways in which staff could identify early warning signs to minimise the risk of repeated events, all of which staff were familiar with. This showed that the provider was pro-active in looking for ways that lessons could be learned and improvements made from incidents that occurred within the home.

Another example to demonstrate that lessons were learned within the service was in relation to medicines. Information we hold showed that an incident had occurred within the home by way of a missed medicine. The acting manager told us that upon review, a decision had been made that only senior staff (team leaders and acting team leaders) were permitted to administer medicines within the home and that all staff had undergone re-training to mitigate the risk of this re-occurring in the future. We checked the medicine systems and processes within the home and found that people received their medicines as prescribed. We saw staff supported people to take their medicines. We saw medications were stored appropriately and staff were aware of the disposal policy for unwanted or refused medication. Processes were in place to identify missed medication early and there was a good rapport between the provider, GP and pharmacy to ensure people received their medication as prescribed. Some people were prescribed medicines on an 'as required' basis, for example for pain relief. We saw that protocols were in place to support staff to administer these safely. Some of these protocols included generic terms such as 'for agitation'. They would have benefitted from additional person-specific detail to ensure that staff were aware of what specific signs and symptoms people may present with to indicate that they were experiencing 'agitation' and required these medicines. This was acknowledged by the acting manager and added without delay.

Everyone we spoke with and observations we made showed that people were supported by sufficient numbers of skilled staff that were deployed effectively to ensure people received the care and support they required. One relative said, "There are always lots of staff around; when we visited the other day, there were four members of staff around [person], all interacting and engaging with him; it's lovely". The acting manager told us they were often over-staffed because the provider wanted to ensure that all staff members were familiar with and skilled to support the people that were living at the home. We saw that shifts were organised so that a team leader, an acting team leader and sufficient support workers were allocated daily duties so that people received one to one support and any additional duties such as cooking and cleaning, were adhered to without impacting on the support provided to people.

We checked two staff files to check that the provider was adhering to safe recruitment practices. We found that the provider had ensured that all pre-employment checks had been completed prior to the staff starting work. These included identify checks, previous employment references and criminal history checks via the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions

and prevents unsuitable people from working with people who require care. Staff we spoke with confirmed that all of these checks had been completed before they had starting working with people and that they had an opportunity to shadow experienced staff before working independently. One member of staff said, "It was a very thorough process, they [provider] made sure my references and DBS were clear and I had the relevant safety training and shadowing before I could start working with people independently".

We saw that the property was well maintained and clean. Records we looked at showed that regular infection control and maintenance checks were carried out; where any actions were required, these were followed up effectively and efficiently. Staff we spoke with were aware of the infection control practices within the home and we observed them adhering to this throughout our visit. For example, we saw staff washing their hands regularly and wearing protective clothing where necessary. Health and safety checks within the home were also carried out to protect people from risks such as legionella and fire. Staff we spoke with knew what action to take in the event of a fire. Records we looked at showed that people had Personal Emergency Evacuation Plans (PEEP) and the provider's fire safety systems (such as the fire alarms, fire extinguishers, fire doors) were serviced and monitored regularly to ensure they were in good working order. The acting manager told us, "We do full evacuations here as practice runs which ensures we are well rehearsed in the event of an actual fire".

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were being cared for in the least restrictive ways possible. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and authorised. There was a system in place to support the management team to monitor the validity of the authorisations and ensure that where additional applications were required, these were applied for in a timely manner.

Records we looked at showed that people and those closest to them, and/or involved in their care had been involved in decisions relating to their care and support needs and, where necessary best interests' decisions had been recorded comprehensively. It was evident that there was a clear understanding of the principles and practices of the MCA within the service. Observations we made within the home showed us that staff were working in accordance with the MCA. We saw staff engaged with people in a way that they understood in order to gain consent and to promote independence as much as reasonably possible. One relative we spoke with said, "They [staff] are brilliant with [person]; it takes a while for [person] to process information but they [staff] are so patient and know him so well, they help him to understand". We saw that information was presented to people in pictorial formats and that staff had been trained in sign language to enable them to engage and promote people's involvement in making day to day decisions and choices.

We saw staff offered people choices about what they wanted to do, where they wanted to spend time, and what they had to eat and drink. One member of staff told us, "We support people to make choices by showing them things or talking and signing at the same time; we also know what people like and don't like so if we need to, we can help them". Staff we spoke with told us that people were supported to do what they liked and to go where they wanted to go. One member of staff said, "We [staff] are allocated to work with people on a one to one so anything they want to do, there is always someone available to help them or to go with them; we would never stop them from doing anything if we can help it; unless it was unsafe of course".

Everyone we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One relative told us, "The staff are brilliant; a lovely bunch of people, they all work together as a team and everyone knows what they are doing; they are very skilled". One member of staff we spoke with said, "The training is excellent, really good". Another member of staff told us that as a new employee, the induction process prepared them with the knowledge and skills they

required to care for people safely and effectively. They said, "This was my first job in care but I was given time to work alongside other staff to learn and get to know people's needs and they made sure I knew about things before I worked alone". We saw that the manager kept a training matrix which detailed the dates when staff had completed various training as well as a rolling programme of updates that staff were registered to undertake throughout the year. There was a comprehensive induction programme and new staff were supported and monitored throughout their probation period to ensure they had the knowledge and skills they required. We also found that staff received regular supervision meetings with either their team leaders or management which provided an opportunity to discuss learning and development opportunities. Staff we spoke with told us that the acting manager was always visible within the home and would offer constructive feedback and praise following observations of their work. One member of staff told us, "I find it really helpful to know what I am doing well as well as things I could do better; [acting manager] is very good at that and it's in a supportive way too which is good". Records we looked at confirmed this.

We saw that people had a good choice about what they ate and they enjoyed the food the staff prepared for them. A relative we spoke with told us that they were pleased with the meals that were prepared for their family member. They said, "[Person] has come on leaps and bounds since being at the home, particularly with his eating; he used to be really fussy about what he ate, but they [staff] have really worked with him on this and now he eats all sorts of food". We found that people were encouraged to participate in weekly shopping and meal preparation in order to promote the development of their daily living skills and independence. There were no set meal times at the home and people ate when they were hungry. One member of staff told us, "because people all have their different routines and we are so activity focussed here now, meal times are just planned in to people's days. So sometimes we will eat out, other times we eat as a group here but people have different meal preferences and choices too so it really just depends". We saw evidence of this during our inspection. We saw people were supported to eat what, when and where they preferred. Staff members took a lead in preparing the main evening meal which looked and smelt lovely. Staff told us that they and relatives were able to join people for meal times which provided more of a family and social feel to the event. We saw people were supported by staff who offered assistance to people where required and people's specific dietary needs were catered for.

Records we looked at showed that all medical appointments were recorded and people were supported to access an annual health check. We found that people had access to doctors and other health and social care professionals as required, including specialist practitioners relating to their specific health conditions. Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent. We also saw that any health care concerns were followed up in a timely manner with referrals to the relevant services.

Good

Is the service caring?

Our findings

Everyone we spoke with and observations we made, all without exception, showed that people were treated with kindness, respect and compassion. One relative we spoke with told us, "The staff are all so wonderful with him [person]. They are always very kind, caring and very respectful".

Throughout our time at the spoke staff spoke about people with genuine compassion and familiarity with many staff likening people they cared for to their own friends and family. One member of staff said, "It's not like work here, I feel like we are just an extended family. I enjoy spending time with them [people] and seeing the difference we can make". Another member of staff said, "I am working a 12 hour shift on Christmas day and I am actually looking forward to spending the day with them here". A relative we spoke with told us, "It [the service] doesn't feel like a care establishment, it feels like [person's] home and the staff are like just one big family. They all work and get on so well together, they know people so well and everyone helps everyone else; it really is a pleasure to visit. We are always made to feel part of the extended family and you can tell the staff want to be there, it's not like it is a job to them and they are there because they have to be".

We saw that people received both practical and emotional support from staff at all times and were treated as individuals. Staff we spoke with new people extremely well and were able to tell us about different people's care needs, any associated risks as well as their hobbies, interests, likes, dislikes and preferences. We saw that people were supported to follow their hobbies and activity schedules were tailored to meet their interests and preferred routines. People's bedrooms were personalised and reflected them as individuals and we saw that people were supported to maintain their individual differences in relation to their personal appearance and style preferences. One relative we spoke with told us, "[person] is always given a choice about what he wants to wear and they support him to make sure he looks neat, tidy and suitable [weather permitting]".

People were involved in all aspects of their care as far as reasonably possible and were supported to make day to day choices because staff made every effort to communication with them in ways they could understand. We saw information was presented to people in various formats in accordance with their needs. Written information was available in large text which was accompanied by pictorial illustrations to aid understanding. Verbal communication was consistently accompanied by sign language and gestural prompts, again to further support people's understanding of questions, choices and instruction. This collectively enabled people to be more involved and promoted their autonomy and independence within the home. One member of staff said, "Communication can be a huge barrier but we have training in different communication styles to ensure that we are being as inclusive and as clear as possible to help people to tell us what they want, need and to help them to be as independent as possible".

People were treated with the utmost dignity and respect. We saw staff respected people's choices and autonomy within the home and spoke to people respectfully with kindness and compassion. Relatives we spoke with told us that this level of courtesy was extended to them also, and their input and relationships with their loved ones was valued. One relative said, "They [staff] are very respectful and understanding. They know it is difficult for us too and they support us with that and involve us as much as possible". Staff we

spoke with gave us examples of how they protected people's privacy and dignity within the home. For example, we were told that one to one support was provided to people in a discrete and supportive manner that enabled them to maintain their personal space whilst feeling secure in the knowledge that staff were nearby. One member of staff said, "[person] likes to use the computer and he can get fed-up with staff being around all the time as he likes his own space, so we will just stand back and let him know we are there if he needs us. We make sure we can see him at all times, but don't overcrowd him". We also heard examples of how staff actively engaged with people in activities of interest so that their presence was considered more as company and companionship opposed to purely observational, monitoring or supervisory purposes.

Good

Is the service responsive?

Our findings

We saw that people were treated as individuals and their personal likes, dislikes, preferences and daily routines were respected and promoted. People and those that were closest to them alongside any relevant health and social care professionals were involved in the planning and review of their care, to ensure that care was specific to their individual needs, preferences and person-centred. One relative we spoke with said, "I am very much involved and my input is valued. I am often asked to go in to discuss his care plans or any changes and we all sit and do it together". We found that people were allocated a 'key worker'. A 'key worker' is a member of staff that has been identified as a consistent point of contact to support people with the planning and review of their care as well as any other assigned care tasks, specific to that person. This promoted consistency to further enhance the person-centred approach. Relatives and staff also told us that it supported communication and engagement between them as it fostered familiarity and helped them to build trusting rapports between people, relatives and staff. One member of staff said, "We make it our business to get to know everyone but as a key worker we are more involved in the planning, review and liaisons for them [people they are key worker's to]; we also make sure that any changes or updates are shared and records are up to date and so forth; it's a good system".

Care records we looked at were comprehensively detailed and person-centred. They reflected what staff and relatives had told us and our observations throughout the day. We saw people engaged in activities that they had identified as meaningful and important to them and staff supported people to spend as much time as possible doing the things they enjoyed. We found that there was a clear activity led culture within the home that promoted people's involvement in daily activities and leisure pursuits. This meant that people benefitted from structured daily and weekly routines, which stimulated their minds and offered opportunities for social engagement. For example, people were supported to access community groups, day centres and partake in activities of interest such as shopping. We also saw people enjoying interactive and more passive activities within the home including drawing and pampering. People also had access to IT systems including the internet. One member of staff said, "[person] loves going on YouTube and listening to his favourite singers; he spends ages on there". Relatives we spoke with told us how staff were always enthusiastic and encouraging of people to get involved in activities and that there had been a significant improvement in this aspect of the service since the acting manager had joined the team as a 'team leader'. One relative we spoke with said, "There is always something going on and [acting manager] has really advocated for the importance of activity in the home, he has made a huge difference and you can see that his influence has rubbed off on all the others [staff]. I can see that [person] is really happy".

We found that the provider often organised social events within the home whereby people's friends and families were invited. Everyone we spoke with and records we looked at showed that these events were well received by all who attended. We saw staff reminiscing with people about the fun that they had had at a recent Christmas party and the provider had received a number of compliments from relatives about the event. One relative we spoke with told us that they had had a lovely time and it was a 'real pleasure'.

People and their loved ones were supported to make decisions related to their preferences and choices about their end of life care. Records we looked at showed that staff had taken the time to discuss different

choices, decisions and preferences that people had about the care and the arrangements they wanted at the end of their life. This information was presented in an easy-read and pictorial format, which detailed where people wanted to spend their final days, those they wanted involved and any advanced decisions or final wishes they would like to have respected. Funeral plans and arrangements were also documented, ensuring that person-centred care planning was maintained even after death. We saw that the provider had received a thank you note from a person's relative which expressed their gratitude for the care they had provided to their loved one, towards the end of their life.

Records we looked at showed that the provider had a compliments and complaints policy which they adhered to. Everyone we spoke with told us that they knew how to complain and they were confident that their concerns would be dealt with appropriately. We found that where complaints had been made, the provider had responded either in writing or had offered the opportunity to meet with those raising the complaint, to discuss their concerns. Improvement plans had been developed and action had been taken to work towards making their required improvements. Information we hold shows that some concerns had also been shared with us about the quality of the service being provided to people, but it was evident that significant improvements had been made in recent months. Everyone we spoke with felt that this was credit to the acting manager and the enhanced activity and person-cantered culture within the home.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. 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.'

However, the service had experienced a high turnover of manager's in its first year of service. We found that the current registered manager had been absent from work since registering with us in November 2017 and there was an acting manager in post. This was the fourth manager to work at the service. It was evident from speaking with relatives, staff and visiting professionals that the inconsistent leadership within the service had, at times, had an impact on the quality of the service being provided to people within its first year. Nevertheless, everyone we spoke with without exception, were extremely positive about the influence that the new acting manager had had on the service and acknowledged the improvements that had been made since their arrival as a team leader, prior to taking on the role as an acting manager.

Comments we received included, "[acting manager] is a real asset; he is brilliant and so enthusiastic, a definite role model for the other staff"; "We can see the difference that has been made since [acting manager] has arrived". Staff we spoke with told us that they felt very supported by the acting manager and valued by their daily input within the service. One member of staff said, "It's great now; he is always around if you need him, he gets involved 'on the floor', you can tell he wants to be out here with us and spends as much time as he can with 'the guys' [people], but he always gets his management duties done too; he is very good". Another member of staff said, "He [acting manager] takes time to listen and is always really positive. But at the same time he tells us when things need to be done".

We found that staff were encouraged to develop within the service but that this was not always accompanied by the right level of support. For example, some of the staff we spoke with told us that at times they felt 'thrown in' to new roles and whilst they appreciated the opportunity, they did not always feel ready for or supported within these new roles or with the additional responsibilities. Some staff felt that this had contributed to some of the challenges the service had faced in its earlier months because the 'wrong people, were in the wrong roles without the right level of experience, expertise or support'. There was a sense that the provider had 'promoted' staff to fill vacant posts without the necessary skills, training, supervision and support to succeed within these roles. We fed this back to the compliance manager at the time of our inspection who acknowledged our findings and offered assurances that the provider was dedicated to recognising staff potential and offering progression within the organisation but recognised that within this service, the staff development initiative may not have always been implemented effectively or as intended. It was evident from speaking with the acting manager and the compliance manager that improvements had been made and that plans were in place to ensure a more stable leadership structure within the service. We will monitor and review the sustainability of this improvement to inform our next inspection.

Quality monitoring systems and processes were in place to ensure that the quality and safety of the service being provided to people was regularly reviewed. This included auditing of care records, health and safety

systems and environmental maintenance checks as well as feedback forums which actively sought the opinions of the people who used the service, relatives, visitors and other stakeholders. Information gathered as part of these systems and processes had mostly been analysed to identify any themes or trends in order to inform where improvements were required, although some areas for improvement were fed back to acting manager. For example, some of the quality monitoring activities were analysed at a provider level, including satisfaction surveys, which made it difficult to learn lessons at a location level for the individual homes. We found that previous managers had failed to use the information shared with them to undertake their own analysis to drive improvements within the individual services. Another example was the collation of information relating to incidents within the home which enabled the staffing team guided by management, to consider ways that they could mitigate future incidents from occurring, or ways to manage similar situations more effectively in the future. However, their findings or actions were not always detailed to evidence this process nor were these outcomes reviewed comparatively to demonstrate their effectiveness in initiating or indeed, sustaining any improvements made. Nevertheless, we did see how feedback they had received in care reviews or by way of the complaints system for example, had been used to inform changes to peoples care plans or risk assessments and how they planned to review these within a set time frame.

We found that the provider's systemic quality monitoring system meant that regional compliance managers also carried out regular monitory visits within home in addition to a dedicated assurance team, for further oversight. We found that the improvements we had been told about in recent months were also reflected in the outcomes of their quality assurance reports. However, some issues we had identified as part of our inspection had not been picked up through these processes. For example, we found the provider had not always notified us of the outcome of applications they had made to the local authority to deprive a person of their liberty, as required by law. Nevertheless, action was taken immediately to submit these notifications to us and it was determined that these had fallen victim to the high turn-over and poor hand-over systems from one manager to another. All other notifications had been received in accordance with the requirements of their registration.

It was clear from speaking with the acting manager and the compliance manager that they were aware of the strengths and areas that required improvement moving forward, including the sustainability of the leadership within the service. Together they discussed ways that this could be promoted and the role the acting manager will play within this, in order to provide reassurance to people, relatives and staff that the improvements seen will be maintained and used to drive further developments.

It was evident that the acting manager had a clear vision for the value of person-centred care and that they were dedicated to promoting and advocating for this within the day to day culture of the home. Everyone we spoke with told us that they felt the acting manager was as a positive role model and led by example, which had clearly had a positive impact upon the improvements noted within the service. Throughout the inspection there was a positive, calm and uplifting atmosphere within the home and we were told that this was a 'typical' day and that every day was like this now. Staff we spoke with expressed their gratitude to the acting manager for the support, encouragement and learning that they had provided to them through their influence as a manager. The acting manager was equally as appreciative for the hard work and dedication of the staffing team and since taking on this new role, had introduced staff incentive and appreciation initiatives which had been well received. One member of staff said, "We get great pleasure from working with people, they are great, but some days can be tough and it is really nice to be recognised and appreciated; a thank you goes a long way, so to get a certificate, card and voucher for your contribution is really nice". The manager said, "They [staff] are a great bunch, they work incredibly hard and it's my personal thank you to them; the provider does advocate for this too".

We found that there was an open-minded and inclusive culture within the home whereby everyone was respected for their contributions and differences. No-one we spoke with raised any concerns about bullying or harassment within the workplace and staff we spoke with told us that everyone was treated equally and fairly. One member of staff said, "We have a diverse staffing team, black, white, Asian, gay...no-one is ever made to feel inferior or different in anyway; it sounds corny, but we are all like one big family". It was evident that this inclusivity was extended to people who used the service and visitors, making the home a friendly and welcoming environment to all.