# Community Homes of Intensive Care and Education Limited

# Ballards Ash

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 23 September 2016 and was unannounced. We returned to complete the inspection on 3 October 2016. The last inspection took place on 5 December 2013 and no breaches of legal requirements were found at that time.

Ballards Ash provides care and accommodation for up to 10 people with a learning disability. At the time of our inspection there were nine people using the service.

There was a registered manager in place at the home. 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.

Procedures were in place to manage and dispense people's medicines safely. Medicines audits were also undertaken. Stock levels that we checked were correct.

There were risk assessments in place to ensure that staff received guidance in how to support people safely. These were reviewed and updated accordingly when necessary.

Staffing levels were assessed and a minimum number of staff required on duty had been set. However, on some days this number fell below the number set by the provider. A recent recruitment drive had resulted in several new members of staff being employed.

Some families and professionals told us they did not feel that people were always supported to make choices around their preferences for participating in individual hobbies and interests.

Staff received support through supervision and training and felt supported by the management team.

Some aspects of the Mental Capacity Act 2005 were not being adhered to and some people were not fully supported by the company appointee to choose how they spent their money.

People received care which was responsive to their individual needs. People were able to follow their own preferred routines during the day, for example by getting up and going to bed when they wished. Staff worked with healthcare professionals to ensure professional advice was sought when necessary.

Staff were kind and caring and treated people with respect. People were encouraged to maintain relationships with other people that were important to them.

The service was well led by the registered manager. Staff reported feeling well supported and able to raise any concerns or issues. There were systems in place to monitor the quality and safety of the service. This

included a programme of audits that included: medicines, the environment and people's care plans.

## 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 ensured people were safe and protected from harm.

People looked comfortable in the presence of staff.

The environment was safe and well maintained.

People received their medicines on time and staff received the appropriate training to ensure they remained competent to administer medicines.

### Is the service effective?

**Requires Improvement**

The service was not fully effective.

In some areas there was a lack of evidence which demonstrated that the principles of the Mental Capacity Act were being fully adhered to.

People told us they liked the meals on offer and people were supported to choose the menu.

People were supported by staff were received appropriate training and who were supported in their role.

### Is the service caring?

**Good**

The service was caring.

People were treated with respect and dignity and personal care was carried out in the privacy of the person's room.

People told us they liked the staff who supported them. Families told us their loved ones were well cared for.

Health and social care professionals praised the registered manager and the staff for their caring approach towards people.

### Is the service responsive?

**Requires Improvement**

The service was not fully responsive to people's needs.

People took part in activities however, concerns were raised by families and professionals that people did not always have access to individual activities of their choosing.

Detailed care plans and risk assessments were in place which were centred on the person's health, care and support needs.

Families told us they knew how to make a complaint and were confident any concerns they raised would be dealt with immediately by the registered manager.

## Is the service well-led?

Good

The service was well led.

Families told us they were very happy with the way the home was managed.

Regular audits were carried out and for the most part, shortfalls in the service delivery were identified and responded to appropriately.

There was an open door policy and families felt they could approach the staff if they had any concerns.

# Ballards Ash

**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 23 September 2016 and was unannounced. We returned on the 3 October 2016 to complete the inspection. The inspection was undertaken by one inspector. Prior to the inspection we looked at all information available to us.

This included looking at any notifications submitted by the service. Notifications are information about specific events that the provider is required to tell us about. We asked the provider 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. The PIR was fully completed and returned to us on time.

During the inspection we spoke with the registered manager who was available throughout the inspection. In addition, we spoke with the activities co-ordinator, the chef, a team leader and two social care workers.

During the inspection we spoke with one relative. Following the inspection we contacted families by email and telephone to gain their views on the quality of the service provided. We received responses from six families. We also received feedback from four health and social care professionals.

As part of the inspection we reviewed the care records for four people living in the home. We looked at staff records and other records relating to the running of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures. Following the inspection we spoke with the regional director who provided us with further information and documents.

Good

# Is the service safe?

## Our findings

Some people were not able to tell us themselves whether they liked living at Ballards Ash, so we observed the care and support they received and how staff interacted with them. Other people told us 'Yes' they liked living at Ballards Ash or smiled or gave their own 'sign' when we asked the question.

The interactions we observed between people and staff showed they were comfortable and happy in each other's company. People approached staff when they needed support and there was a good rapport. Families commented "I have never had cause for concern about my loved one's safety in all the time they have lived at Ballard's Ash" and "I truly respect and trust the registered manager and the team members that I have had the pleasure to meet so far". Families specifically highlighted how well the home managed complex behaviour and because of this felt the risks to their loved ones and others were reduced.

People using the service could be confident that their medicines were organised and administered in a safe, competent manner. People received their medicine on time and staff were knowledgeable about the type of medicines people took and why they were prescribed. Medicines were stored in a room in lockable cabinets which only designated staff had access to. The temperature of the medicine cabinets were monitored to ensure they remained at the correct temperature in line with the manufacturer's instructions. At the time of our inspection the temperature of the room was not being recorded. By monitoring the room temperature it allows action to be taken should the room become too hot or cold. Some medicines may lose their effectiveness if not stored as required. By the second day of our inspection, staff were recording the daily temperature of the medicine room.

Staff were pro-active in ensuring that people were free from pain through monitoring and responding to people in a timely manner. We observed a member of staff asked one person if they were in any pain and the person shook their head to say 'No'. Records showed that medicine stock levels were accurate and balanced with the number of medicines which had been dispensed. There were protocols in place for the administration of medicines that were prescribed on an 'as and when needed basis' (PRN medicines).

Some people were given their medicine without them knowing it was medicine, such as when given in yoghurt. The person's GP had determined the person's ability to understand the impact of not taking their medicine and a decision had been made in the person's best interest. Medicines were reviewed with the GP on an annual basis or where needs changed. Some people were prescribed drugs which may have a sedative effect on them and these were administered responsibly by staff. This meant people received these medicines only when required and as prescribed.

Staff who had responsibility for administering and disposing of medicines undertook training and regular assessment to ensure they remained competent to deal with medicines.

Safeguarding training was undertaken by all staff. Through our discussions it was clear staff were aware of what constituted abuse and their responsibilities in reporting it. Where required, the registered manager submitted notifications to the CQC to inform us of any incidents.  Incident and accidents were monitored

and reviewed for trends or patterns. This enabled the service to review and amend risk assessments as required.

We reviewed the staff files for three members of staff. This demonstrated the provider followed safe recruitment practices to ensure new staff employed were appropriate to work with vulnerable people. This included ensuring that an enhanced DBS (Disclosure and Barring) had been granted and references sought for the suitability of the new member of staff.

The provider acted as a company appointeeship for some people. This meant they undertook the responsibility of ensuring people's payments from the Department of Work and Pensions were managed safely and appropriately. The provider policy called 'Basic Financial Procedures' did not make it clear the level of responsibility the provider would assume in the event that money was mis-used. Following the inspection, the provider amended their policy to reflect this and clarified that the company appointee would ensure that people would be recompensed in any such event.

The environment was safe for people. The interior and exterior of the home was well maintained. There was appropriate lighting and walkways were clutter free. Communal area's had non-slip flooring which was warm underfoot. Six bedrooms were located on the first floor which was accessed by a staircase. As the home did not have facilities such as a stair-lift, the registered manager ensured that people's mobility was reviewed. They told us "no one on the first floor has mobility concerns which means they would be able to use the stairs should we need to evacuate the home".

Fire extinguishers were contained within a 'fire box' affixed to the wall. There were clear signs to indicate fire exits and personal evacuation plans were in place in the event of a fire in the property. Access to the kitchen was through a key code and to ensure safety, people were free to enter the kitchen if staff were in that area.

People used a variety of equipment to assist in their care such as a pressurised mattress. Equipment was checked to ensure it remained safe to use and for wear and tear. Various risk assessments were in place to minimise the potential of identifiable risks to people. These related to individuals and their care and support needs such as, epilepsy care, positive behaviour management and sexuality. Other risk assessments related to activities out of the home.

The provider had risk assessments in place for the environment and facilities, such as ensuring the water systems were regularly checked for legionella. [Legionella is a disease which is caused by bacteria in water systems]. Fire equipment was regularly tested and staff reported any maintenance issues to the management team to ensure repairs were carried out swiftly.

Prior to our inspection the registered manager had identified steps they needed to take regarding their staffing levels. The registered manager told us "the home is not on the main bus route and it can be very difficult for staff to get here without a car. This hasn't helped in our recruitment".

The provider had a system in place which determined the minimum number of staff which should be available for each shift. Monitoring records showed that more recently the minimum number set was not always being met. This had not compromised on people's safety but did determine what activities people took part in and how people were supervised whilst in the home.

Following the inspection, the registered manager was able to update us on their progress with recruitment. Two people had been offered a full time social care worker position. One person was offered the waking night social care worker position and two bank members of staff were recruited for cover. They had also just

interviewed for an assistant manager and would continue to advertise for current vacancies. In the interim agency staff were being employed to cover staff absences such as sick leave. The registered manager recognised that the staffing levels had impacted somewhat on individual's one to one recreational time.

Should the premises need to be vacated in an emergency, transport was available and alternative accommodation had been arranged for people in one of the provider's other homes.

Requires Improvement

# 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection we checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. Applications for authorisations of a deprivation of liberty had been made to the supervisory body. The registered manager explained that applications had been submitted, however, they continued to follow up those applications which were still awaiting assessment.

Records demonstrated that capacity assessments and best interest decisions had been undertaken for some areas of people's care and treatment, such as people having covert medicines or dental treatment. Best interest meetings involved the person, family, staff members and other health and social care professionals. However, we found this process had not been followed in other areas of decision making.

We reviewed the care records of four people. In one person's care record, a capacity assessment had been completed for their consent to care and treatment, however, there was no information around how the service had supported the person to be involved in the decision making process.

During our inspection we observed there was a practice of using audio monitors to listen to people if they were alone in their room. The registered manager told us this was only for some people who may be at risk of an epileptic seizure. There were no assessments in place for people making a specific decision around the use of this equipment or an application made regarding a deprivation of the person's liberty.

Following the inspection, the registered manager completed a mental capacity assessment for the relevant people regarding the use of the audio monitors, and provided us with evidence of the assessments. However, we found there was a lack of information as to how the service had tried to involve the person in making the decision, for example what resources were used to communicate the subject in an accessible way, how often and when was the best time to try and illicit the person's views or who was the best person to communicate the subject. The registered manager informed us following the inspection that DoLS applications had been made to the necessary authorities.

Each person had a financial profile which highlighted how their money was managed and which aspects the person was involved in. The provider was allocated as a company appointee. People's money was paid directly to the company appointee.

The registered manager monitored people's finances and met annually with people and their families to discuss what had been spent. Some people had been supported to make decisions about how to spend their money, such as purchasing a car, furniture or a holiday. However, we found for other people there were large amounts of money accruing in their personal bank accounts.

The registered manager told us they regularly reviewed people's money and it was used for one to one interests or hobbies the person may have. The regional manager told us they used the 'living the life tool, which sets goals and talks about learning and developing and anything that the person would like to do or achieve'. We found there was a lack of information about people's wishes and choices about how they would like to use their money, planning for this and checks that people were accessing their money for their chosen activities.

The registered manager and staff had varying levels of understanding of the Mental Capacity Act 2005, however their knowledge was at a level which was relevant to their role. Staff had received training in this area.

The chef was pro-active in enabling people to make choices about the menu on offer because people could make choices visually. Each person was asked to choose the menu for the week. Pictures of different types of food were available and the person chose an option for lunch, dinner and supper. The chef told us they supported the person to think about healthy options and to ensure there was a variety of food over the day. The chef had considered good nutrition when devising the pictorial planner to include proteins, good fats, vegetables and fruit. All food was home made. The chef had a good understanding of specialised diets including diabetes which was diet controlled.

People were supported to eat their meals if they required assistance. Staff were attentive and encouraged people to eat at their own pace. The chef told us people had a good appetite and enjoyed the food on offer. At the time of the inspection there were no food or fluid charts in place as people were maintaining a healthy weight. The chef kept records of people's likes and dislikes around food and people were able to make suggestions for the menu. Records demonstrated that referrals to either the dietician or speech and language therapist had been made if people required support with their diet or had difficulty in swallowing food and were at risk of choking.

Families told us when they visited the home they often stayed for lunch. On the first day of the inspection we saw one person was in the kitchen chatting to the chef. The chef told us this was the norm as people liked to come in and see what was cooking. People also liked to help with cooking or baking and were able to choose a meal from pictorial recipes. They also went out shopping for the food and then cooked the meal with the support of the chef.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People had a 'health action plan' which described the support people needed to stay healthy such as ensuring treatment plans were in place for epilepsy. People's health was monitored to ensure they received prompt care and support and timely referral to professionals were made.

Newly appointed social care staff went through an induction period which included shadowing an experienced member of staff. Staff told us they had completed training at the start of their employment and received regular updates. All staff said they felt they had the necessary skills and knowledge to undertake their roles, although staff did identify they would appreciate training in sign language as it would enhance the way they communicated with people. Staff we spoke with and observed demonstrated they had the

necessary knowledge and skills to meet the needs of the people using the service. They were able to describe people as individuals. Staff knew about people's likes, dislikes and preferences.

Staff were aware of their roles and responsibilities. Training records confirmed staff had received the core training required by the provider, such as safeguarding, infection control, manual handling and health and safety. Staff also undertook more specific training relevant to the support needs of the people they cared for such as, understanding autism, positive behaviour management, epilepsy awareness and diabetes management.

The registered manager told us they had experienced some difficulties due to the turnover of staff. As new staff joined the team, it meant that additional support was needed from other members of the team until the member of staff was confident in their knowledge of people. Families and a health professional commented they felt the on-going changes in staff had impacted on how people spent their day. This was because new staff needed to get to know people and it took time to develop new relationships with people.

Staff met with the registered manager on a regular basis. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. During these meetings, guidance was provided in regard to work practices and opportunity was given to discuss any difficulties or concerns staff had.

Good

# Is the service caring?

## Our findings

People used different means of communication, from communicating verbally, to using sign language or signs relevant to them. Some people used facial gestures or objects of references. We asked people if they liked the staff, some people smiled, one person clapped their hands and some told us 'Yes', they did like the staff. We observed that all staff were kind, caring and friendly towards people.

All of the families we contacted told us they felt their loved ones were 'happy' living at Ballards Ash and were well cared for. Comments included "I can't fault the place", "staff are very good, very caring and kind with everyone", "I've never had a concern regarding the quality of my loved one's care, staff are always respectful towards them", "my experience of the staff are totally positive and I believe my loved one to be very happy at Ballards Ash" and "it's an excellent home, staff are wonderful, they treat everyone with respect and dignity. When [name of person] comes home to visit, within two days they want to go back to Ballards Ash".

Health and social care professionals praised the registered manager and the team for their caring approach and comments included "The manager is excellent, is very caring and not afraid to challenge when required to advocate for the service user" and "they really care about people and I would say they [people] are happy".

Our observations demonstrated that staff were attentive to people's needs. The staff knew people's likes and dislikes and their preferences for the way care was delivered. This corresponded to the information in people's care records. People had a document called 'things I like most', this included important information to that person, for example if they had a key to their room, what their preferences were for personal care or special words which would reassure them if they were upset.

Families saw positive outcomes when they visited their loved ones. A relative told us "our loved one tells us about their holidays and the stories staff tell her, we know she feels part of a large family. They have helped her to express her individuality and style and she has really grown in confidence in both her speech and behaviour".

When people required personal care, staff discretely asked them to move to their room to ensure privacy. At all times staff spoke with people in a respectful and caring way. People joined in banter with staff and staff understood people's wishes.

Requires Improvement

# Is the service responsive?

## Our findings

Feedback from some families and professionals raised the issue of a lack of choice available to people in respect of individual daytime activities and occupation. The consensus was that people were predominately participating in group activities and not enough consideration had been given to whether people would choose that group activity or if the activity met their needs. Families also considered that the lack of one to one activities had been on-going for some time. We found there was a lack of information available in people's care records around supporting people to take part in activities of their choosing, monitoring this was happening and evaluating the outcome.

A health and social care professional did raise their concerns around one person who had a mobility car because it had been used 'four times per month'. They did not feel the car was being used enough to benefit the person. They also felt that individual activities which they knew the person enjoyed were not being considered and told us they would like to see a more proactive approach to arranging activities. Another health and social care professional told us they felt there was a lack of choice available for the person they supported.

Families had expressed a concern that the potential 'high turnover of staff might put chosen activities at risk'. We discussed the lack of individual activities with the registered manager. They told us this was due to the current staffing levels which they were confident would soon be addressed following a recent recruitment drive. The service had identified through its auditing system that limited activities may 'impact on people leading a full and active lifestyle of their choosing'. The last audit stated this had improved however did not give an action plan of how this would be fully addressed.

The week before our visit, people had returned from a trip to Butlin's and staff told us everyone had enjoyed the break. The activities co-ordinator described some of the activities which people took part in such as, theatre trips to London, ice-skating, trampolining and horse riding. People also attended a local social club where they could meet their friends. The activities co-ordinator explained how they met with people to talk about the type of activities they would like to take part in. They used picture cards to gain people's idea's to plan activities.

Each person had a weekly activity planner in a pictorial format which listed the activities they took part in. At the time of our inspection the activity co-ordinator was due to go on annual leave. The registered manager explained this meant activities would be more ad hoc rather than activities on the scheduled planner until the staff member was back from annual leave.

During the two days of the inspection, one person visited their family home and some people went out for lunch. Another person took part in a musical session playing the drums whilst the tutor played and sang on the guitar. The person told us they liked playing the drums. Staff told us other people also enjoyed these music sessions and one person was creating their own music and transferring this to a CD. People also enjoyed massage sessions. For the most part of our inspection, people sat together in the lounge and watched television, one person played on an electronic I-pad and another used a foot spa.

People were encouraged to keep in contact with their families and friends and enjoyed days out with them or trips to the family home. Families told us they were no restrictions on visiting and they could drop into the home at any time and were always welcome. People participated in daily routines such as making their own breakfast, setting the table, helping to make their bed, tidying their room or helping to fold the laundry. The service used a tool called 'Living the life' which was a developmental tool aimed to help people set individual goals which were then measured by staff towards their progress. In one plan the overall goal was to 'set the table', however, the grading used to measure the progress of the person did not fully enable small steps to be recognised as an achievement, thereby acknowledging all achievements, however small. We discussed this with the registered manager who advised us they would review these documents.

People were supported by staff who understood their individual needs and preferences. For example, people were able to follow their own preferred routines such as when to get up and go to bed. The registered manager told us people and their families were involved in the development of care plans. Information about how people preferred to communicate was included in their support plans. However, people did not have a copy of their care plan in an accessible format to enable them to more fully participate in the process. The registered manager told us they were looking into developing a one page pictorial summary of the person's agreed care plan and would action this as soon as possible.

Personalised care plans were in place. Support plans were clearly written and gave a good picture of people's individual needs. This ensured there was consistent guidance in place for staff to follow. Support plans were evaluated on a regular basis to ensure they were current and reflected any changes in the type of support that people required. There was information available in people's support files describing their lives prior to coming to the home, including important events in their lives and relationships that were important to them. This helped staff understand people as individuals.

Risk assessments and support plans were in place which were individual to the person and which accommodated an element of risk taking. This was in relation to care and support, health care and activities. Where people may present with behaviours that could potentially affect others, there were individual plans in place to guide staff in managing this. These plans described the situations that may trigger these behaviours and how staff could support the person at these times. For example, the impact that loud noises could have on one person and the resulting response. Where relevant, the plans had been developed with input from a specialist health professional, a psychologist who was employed by the provider.

The provider had a complaints policy in place which was displayed in the home. There was also a policy which was intended for people who live at Ballards Ash to use and was in a pictorial format. This document was over five pages long and very detailed in content. We asked the registered manager if they had a document which was more concise and which supported people to better understand the message. They told us they were introducing a card system which would denote either a happy or not happy picture on a card.

Following the inspection, the registered manager informed us they had given people the cards. The aim was that people would give a member of staff one of the cards if they were happy or not happy with something. The home were to monitor how the cards were received and if they supported people to voice their opinion and raise concerns. Families told us they had no complaints. If they had raised concerns, this had been addressed to their satisfaction by the registered manager.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post and they were available throughout the inspection. They told us "we [the team] are committed and passionate in what we do and treat everyone with dignity and respect. We aim to achieve high standards to give people a stimulating life, where they have opportunities for new experiences".

Families and health and social care professionals spoke highly about how the home was managed and their relationship with the registered manager and the staff team. Comments included "the manager is absolutely brilliant" and "couldn't ask for a better team especially with the manager they have". There was particular praise from a health professional who told us "the registered manager has worked tirelessly to support one extremely complex and challenging individual".

Staff were aware of the organisation's visions and values. Comments included "this job is about helping people to enjoy a good quality of life" and "I love my job and seeing how people progress and develop as individuals". Staff told us they felt 'very' supported by the registered manager, both in and out of the work place. They told us "this is a lovely home, lovely team and we pitch together" and "we [the staff] are very good towards each other". Staff reported there was an open door policy where they could approach the registered manager at any time. Staff told us that morale was improving following a recent recruitment drive for staff.

The registered manager told us they regularly worked as part of the team. In part, to observe staff practice but more recently to fill in for staff shortages. During our inspection we observed this was the case. They explained this had impacted on their ability to 'keep on top' of administration. Although, they were positive this would be a temporary situation with positions being offered to new staff. There had been a fairly high turnover of staff which the registered manager told us they continued to monitor, although felt the rural location of the home did impact on their staff retention.

The provider had systems in place to monitor the quality of the service. This included audits carried out by the home manager and a quality assurance team. The audits covered the areas of safe, effective, caring, responsive and well led. The audits reviewed infection control, staffing, care plans, the safe management of medicines and health and safety. Areas requiring action were identified and we saw a record of follow up actions. There were some areas which the audits had not identified, such as monitoring the temperature of the medicine room and in ensuring the Mental Capacity Act had been adhered to.

The systems and processes in place for the overall management of the home was centralised and various departments at head office level took the lead, for example, a specific department was responsible for carrying out the annual review of people's care needs. The registered manager was involved in these processes but did not always have all of the relevant information expected of their role. For example, we asked where people have a 'lasting power of attorney (LPA)' for finances or health and welfare, how they monitored that the person holding the LPA had the legal authority to make decisions. They were not able to tell us and this enquiry was passed on to the regional manager who explained the procedure in place.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented.

People's relatives told us they were regularly involved with the service and reviewing their family member's care and support. They told us they could raise concerns or make suggestions on how best to support the person.

The provider worked in partnership with other health and social care professional and organisations to support care provision. This included the local advocacy service, occupational therapists, consultants and healthcare professionals.

We asked the registered manager how they kept up to date with good working practices. They said they attended regular meetings with other managers of the different provider locations. This gave them the opportunity to share information and ideas. The home formed links with the local community, such as through using local services, social clubs, country parks and shopping.

We discussed with the manager any plans they had for improving the service in the coming year. They told about the on-going recruitment of staff and their plans to build the team. They were also to purchase some new furniture and they were going to show people pictures of different styles and colours for them to choose the furniture they liked best.

There was an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised. There were procedures in place to guide staff on what to do in the event of a fire or to evacuate the premises in the event of an emergency.