Voyage 1 Limited

Walker Lodge

Inspection report

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Date of inspection visit: 9 February 2015
Date of publication: 22/04/2015

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

Overall summary

This unannounced inspection of Walker Lodge took place on 9 February 2015.

Located in a residential area and close to local community facilities, Walker Lodge is registered to provide specialist care for up to eight people with an acquired brain injury. The home is a purpose built facility with accommodation located over two floors. A passenger lift is available for access between the floors and the building has been designed to ensure full access for wheelchair users. There are a number of car parking spaces adjacent to the home.

Eight people were living at the home at the time of our inspection. This was the first inspection of the home since its registration with the Care Quality Commission in 2012.

A registered manager was in post. 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.

Summary of findings

People said they felt safe living at the home and that staff were never unkind towards them. Staff understood what abuse was and the action they should take to ensure actual or potential abuse was reported.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People and their families told us there was sufficient numbers of staff on duty at all times.

Our review of a selection of care records informed us that a range of risk assessments had been undertaken depending on people's individual needs. There was a culture of positive risk taking within the service.

Some of the people living at the home used bedrails and a detailed risk assessment had been undertaken for all the people who used this equipment in order to establish if it was safe for them to use.

People told us they received their medicines at a time when they needed it. Robust processes were in place to ensure medicines were managed safely and in accordance with national guidance.

The building was clean, well-lit and clutter free. The environment was suitable to the needs of the people living there. Measures were in place to monitor the safety of the environment.

Families we spoke with told us the manager and staff communicated well and kept them informed of any changes to their relative's health care needs. People said their individual needs and preferences were respected by staff. They were supported to maintain optimum health and could access a range of healthcare professionals when they needed to. The service had access to specialist therapy services.

There was a clear person centred culture within the service. People told us they were encouraged to be involved in developing their support plans and weekly schedules. People were actively encouraged to engage in local activities and develop relationships within the local community.

People were encouraged and supported to develop their own weekly menus, participate in purchasing their own food and either fully prepare or be assisted with the preparation of their meals.

People who lived at the home and families described management and staff as caring, considerate and respectful. Staff had an excellent understanding of people's needs, preferred routines and aspirations for the future. We observed positive and warm engagement between people living there and staff throughout the inspection.

Staff told us they were well supported through the induction process, regular supervision and appraisal. They said they were up-to-date with the training they were required by the organisation to undertake for the job.

People living at the home were consistently encouraged and supported with decision making. The registered manager and staff had an excellent understanding of the Mental Capacity Act (2005). Where people lacked mental capacity the principles of the Mental Capacity Act had been applied appropriately.

The culture within the service was and open and transparent. Staff, people living there and families said the registered manager was approachable and inclusive. They said they felt listened to and involved in how the service developed.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it. Opportunities were in place to address lessons learnt from the outcome of incidents, complaints and other investigations.

A procedure was established for managing complaints and people living there and their families were aware of what to do should they have a concern or complaint. We found that complaints had been managed in accordance with the complaints procedure.

Audits or checks to monitor the quality of care provided were in place and these were used to identify developments for the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Relevant risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

We observed that medicines were managed safely.

Measures were in place to regularly check the safety of the environment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff encouraged people to make their own decisions and followed the principles of the Mental Capacity Act (2005) for people who lacked the mental capacity to make decision.

People were encouraged and supported with menu planning, food shopping and preparing their meals.

People had access to a range of healthcare professionals and were supported by staff to attend appointments. People also had access to specialist therapy services.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

Is the service caring?

Good

The service was caring.

People told us they were happy with the support they received. We observed positive engagement between people living at the home and staff.

Staff treated people with privacy, dignity and respect. Each person had their own individual communication plan. Staff had an excellent understanding of people's needs and preferences.

Families told us the registered manager and staff communicated with them effectively about changes to their relative's needs.

Is the service responsive?

The service was responsive.

People's support plans were regularly reviewed with them. The support plans reflected people's current needs.

People living at the home and their families said the care and support was individualised and requests for support were responded to in a timely way.

Summary of findings

A process for managing complaints was in place. People and families we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the open and transparent culture within the home. Staff, people living there and families said they felt listened to, included and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Processes for routinely monitoring the quality of the service were established at the home.

Walker 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 was 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 unannounced inspection took place on 9 February 2015 and was undertaken by an adult social care inspector.

Before our inspection we reviewed the information we held about the home. Usually we request a Provider Information Return (PIR) prior to inspection. On this occasion we had not requested a PIR. The PIR 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. Prior to the inspection we looked at the notifications the Care Quality Commission (CQC) had received about the service and any information received from health and social care commissioners.

During the inspection we spoke with four people who lived at the home and three family members who were visiting at the time of the inspection. We spoke with the registered manager, the operations manager, two of the care staff team and an occupational therapist.

We looked at the care records for four people, three staff recruitment files and other records relevant to the quality monitoring of the service. We undertook general observations, looked round the home, including some people's bedrooms, bathrooms, the dining room and lounge areas.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe living at Walker Lodge and confirmed the staff were never unkind towards them. Visiting family members supported this view. A family member said to us, "I have never heard anyone speak or treat people badly here." People told us they would approach the registered manager if they had any worries about how staff treated them.

Staff we spoke with were familiar with the home's procedure for safeguarding vulnerable adults and were clear about the process to follow should they have concerns about the safety of people living at there. The procedure was in line with the local arrangements for safeguarding adults. Training records informed us the staff team was up-to-date with training in the safeguarding of vulnerable adults. A safeguarding vulnerable adult's procedure was in place and it had been reviewed in October 2014.

People told us they received their medicines at a time when they needed them. They said staff explained to them what their medicines were for and in a way they understood. We spent time with a member of staff who had lead responsibility for ensuring the safe management of medicines. A medicines profile was in place for each person. It included the person's diagnosis, known allergies and brief background history, their preferred times to take medicines and whether it needed to be given with food. The profiles were supported by information sheets about the medicines each person was taking.

In addition, detailed plans were in place for medicines people took only when they needed it (often referred to as PRN medicines). Body maps were in place to show staff where topical medicines, such as creams should be applied. A process was established to monitor medicines people took when they were outside of the home for extended periods, such as when people were visiting their family.

The medicines were secured in a locked trolley and the trolley was stored in a dedicated locked room when not in use. We looked at the medicines policy and noted the arrangements for managing medicines were carried out in accordance with NICE guidance for managing medicines in care homes. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care. Checks were in place for the use of PRN medicines and controlled drugs (these types of medicines are regulated under the Misuse of Drugs legislation).

A handover checklist was in place for staff changing shift to ensure all medicines checks were up to date. Although the home was not using medicines that required refrigeration, the temperatures for the medicines fridges were monitored and recorded daily in accordance with the home's policy. The medicines room temperatures were also monitored on a daily basis. We could see from the records that staff who administered medicines had a competency check each year.

The four care records we looked at showed that each person's risks were taken into account in the way care and support was planned. This was done in a person centred way with an emphasis on positive risk taking. We discussed specific risks for people with the registered manager and staff that we read about in the care records. They demonstrated a clear and consistent understanding of how individual risks were managed in accordance with the person's support plan. We observed that some of the people living at the home had bedrails in place. The manager confirmed these were used to keep people safe by preventing falls from the bed. We could see that detailed bedrail risk assessments were in place.

Using an example, the registered manager showed us the process for managing incidents. We could see from the example that any action taken was recorded. The registered manager advised us that each incident was reviewed to see if it could be avoided in the future. Staff informed us that incidents were discussed at handover between shifts and at staff meetings.

Staff were trained in Nonviolent Crisis Intervention (NCI), which is a safe, non-harmful type of physical intervention used as a last resort when all other intervention techniques have been exhausted. Staff we spoke with were unable to recall when NCI was last used as they said other techniques, such as de-escalation were successful in calming situations.

Most of the people living at the home told us there was enough staff on duty to ensure their needs were met in a timely way and that they received support from staff when they needed it. One person said on occasions there were not enough staff and they had to wait for assistance. They

Good

Is the service safe?

told us they did not have to wait long. The family members we spoke with said the staffing levels were very good. We discussed staffing levels with the registered manager who advised us that the staffing levels for the eight people living there was a manager, senior support worker and two support workers during the day. There were two support workers on a waking night shift. The registered manager told us there had been an increase in staff sickness between November 2014 and January 2015, which may account for a person mentioning low staffing levels.

We looked at the personnel records for three staff. We could see that a rigorous recruitment process was in place and a formal check had been carried out to confirm each member of staff was suitable to work with vulnerable adults. At least two references had been obtained for each of the staff. We spoke with a member of staff about how they were recruited for the job. They told us they started once all the recruitment checks had taken place, including a medical check to ensure they were fit to carry out their role.

The provider had contract agreements with a range of therapists who provided input to a number of services within the organisation, including a physiotherapist and occupational therapist. During the inspection it was not clear how the organisation monitored whether the professional registration and continuing professional development was up-to-date for the therapists. We received an email from the registered manager after the inspection providing assurance that a system was in place to monitor that therapists were up-to-date with their professional registration and training.

Arrangements were in place for monitoring the safety of the building and equipment. An environmental audit took place in September 2014. Routine environmental safety checks were carried out on a regular basis. The registered manager explained that an electronic system was established to raise any maintenance needs and advised that maintenance was addressed in a timely way. Documentation was in place to demonstrate that wheelchairs, standing equipment and hoists were regularly checked and/or serviced to ensure they were safe to use. The hoist slings were checked each day and a record made of the checks.

In addition, arrangements were established to ensure the service was working in accordance with infection prevention and control (IPC) guidance. There was a nominated IPC lead who had received the required training for the role. We could see that cleaning schedules were in place and checklists were routinely completed to confirm the schedules had been followed.

Good

Is the service effective?

Our findings

People we spoke with said staff prompted and supported them to look after their health. They said they could see a healthcare professional, such as a GP, when they needed to. Staff told us they encouraged people to be independent by attending primary health care appointments in the community with support rather than healthcare professionals calling to the home. Family members we spoke with told us the staff acted promptly if their relative developed a need that required input from a doctor, nurse of other healthcare professional.

We could see from the care records that people had a detailed assessment before they moved to Walker Lodge. This included an in-depth social history and a psychology assessment. This meant people were receiving a holistic and multi-disciplinary assessment to ensure the facilities, resources and expertise were available at Walker Lodge to meet their needs.

The care records confirmed that people had access to primary healthcare professionals when they needed it. The service had established links with and access to specialist healthcare services when required. These included neurology, psychiatry, psychology and specialist services for acquired brain injury. We could see from the care records that people had or were currently involved with some of these specialist services. Some people had input from a speech and language therapist (SaLT) if they had needs associated with swallowing or speech. We could see that the advice and guidance from specialist services was incorporated into people's individualised health and wellbeing support plans. This meant people's care and support plans were developed based on a comprehensive integrated multi-disciplinary approach.

A behavioural therapist was employed by the organisation and the registered manager advised us that they could contact and request the input of the behavioural therapist if a person needed this service.

Meals were planned based on individual need. The registered manager told us that three people living there had their own food budget. They were supported each Saturday to plan their meals for the week and staff then supported them individually with the food shop. People we spoke with confirmed this arrangement. They said they liked planning their meals and shopping for their food. Staff usually supported each person with meal preparation but sometimes the occupational therapist did this to assess a person's skills in the kitchen. Each person had their own time for preparing their meal in the kitchen. This meant the kitchen did not become overcrowded. We observed the occupational therapist supporting a person to prepare their lunch on the day of the inspection.

Five people were unable to physically prepare their meal so staff did this. A family member told us that their relative went into the kitchen and stayed with the staff who was cooking their meal. The family member said their relative could choose what to have. They told us, "Mealtimes are great. Everyone is in and out of the kitchen. It's like being in your own home."

We observed the lunchtime meal and noted that nobody had the same meal. Some people ate in the dining room. Others dined in the lounge. Some people ate at different times. Nobody was rushed with their meal and plenty of staff support was available if needed. People living there told us they could have drinks whenever they wanted one. People who were more independent made their own drinks.

A person who lived there said he sometimes dined in the 'practice' kitchen with another person he lived with. The 'practice' kitchen was used for people to develop skills with cooking and meal preparation. Staff advised us it had height adjustable work surfaces, sink and cooker to accommodate people who used wheelchair users.

A culture of person centred support was clearly promoted within the service. 'Person centred' means the individual needs of the person and their wishes and preferences are at the centre of how the service is delivered. This also meant decisions were made with the person rather than about the person. We observed and overheard numerous examples throughout the inspection of staff subtly prompting and encouraging people with decision making. This was important as some of the people living there experienced short term memory loss. A person said to us, "The staff tell me what to do and what is going to happen." The person said this was good because they "couldn't always remember what was going on."

Each of the care records we looked at included a decision making profile for the person. Decisions that people could make independently were clearly recorded alongside how

the person made and/or communicated each decision. Decisions the person required support with and the people that needed to be involved in supporting them to make each decision were also recorded.

The registered manager had an excellent understanding of the Mental Capacity Act (2005) and how it applied to the service. The Mental Capacity Act (2005) is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The registered manager advised us that if it was identified a person needed support with making a decision then a mental capacity assessment was undertaken followed by a best interest meeting with the relevant people who needed to be involved. We were provided with the paperwork to demonstrate this best interest decision making process for a person living at the home.

One person was subject to a Deprivation of Liberty Safeguards (DoLS) plan and the staff we spoke with were clear about the reasons why the plan was in place and their responsibilities with ensuring the plan was followed. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. DoLS applications had been completed for other people living there and had been forwarded to the Local Authority. One of the people was subject to a Community Treatment Order (CTO) under the Mental Health Act (1983) and staff were clear about their responsibilities in ensuring the conditions of the CTO were adhered to.

Training records informed us that the staff team had received training in mental capacity. We observed that brief bullet point information about the Mental Capacity Act and DoLS was displayed in the office and areas which staff accessed. The registered manager confirmed this was in place to constantly remind staff of the principles of The Act.

We could see from the personnel records we looked at that new staff worked to an induction plan and a record of the progress with the induction plan was maintained. We spoke with a member of staff about their induction when they first started working at the home. They said the induction was thorough and they had two weeks of supernummary time shadowing a more senior member of staff. They told us they were not allowed to undertake certain activities, such as moving a person with a hoist, until they had been trained and were deemed competent. During the induction the member of staff said they completed required training for their role and read the care records for the people living there, and other relevant service documentation.

'One page profiles' were in place for each of the staff. These included a photograph and brief overview of the staff. New staff were provided with these profiles so they could get to know the staff team. The registered manager advised us that people living at the home could also have access to the 'One page profiles' for staff.

The staff we spoke with told us they were up-to-date with the training the organisation required them to complete (often referred to as mandatory training). This was a combination of computer based and face-to-face training. The registered manager showed us how the training was monitored electronically and we could see that staff training was current. It showed a 93% compliance with training. The outstanding 7% was due to new staff starting who had not fully completed the training. In addition to required training, staff told us the registered manager organised training or awareness sessions specific to the needs of people living there. The registered manager confirmed that individualised training regarding a person's needs was delivered in staff meetings. The training was facilitated by one of the therapists if it was in relation to a defined plan for a person living there. This meant staff were receiving bespoke training related to needs a person need specific support with.

The senior support worker told us that senior staff had the lead or were 'champions' for specific topics. For example, a member of staff was the lead for medicines management and this meant it was their responsibility to ensure that medicines were managed safely and in accordance with the organisational policy. Furthermore, another member of staff was responsible for monitoring staff training and regularly monitored the system to check if any training was due. The registered manager confirmed that support workers also took the lead for topics and one of the support workers was responsible for nutrition and ensuring that the weekly menu planning meetings happened.

Clear arrangements were in place for staff supervision and appraisal. The senior staff had an allocated group of

Good

Is the service effective?

support staff to supervise and appraise. Supervision took place every eight weeks and each member of staff had an annual appraisal. Staff we spoke with confirmed they were up-to-date with their supervision and appraisal.

The design and layout of the environment was suitable to meet the needs of the people living there. The wide corridors and widened door frames were supportive to the people who were wheelchair users and those who had limited mobility. Bedrooms and shared areas were spacious to accommodate people's mobility needs and the use of moving and handling equipment. The front and back door was accessible for wheelchairs. People had access to a garden area at the back of the building, which provided a covered area for the people who smoked. Some people experienced short term memory loss so clear signage on doors was supportive for people to find their way about.

Good

Is the service caring?

Our findings

The people we spent time with spoke positively about the staff. They said staff treated them kindly and with respect. Some people had communication needs and they told us staff took the time to listen to them and they did not feel rushed. Regarding the staff a person said, “They are nice and friendly.” Another person said, “You feel like you matter.” People told us they could have visitors whenever they wished. They also said they could have a key for their bedroom door if they wanted.

Equally, family members spoke highly of the staff team. They said staff responded quickly if people needed something and they were not left waiting. A family member told us “My [relative] likes all the staff. There is a lovely atmosphere here. It is the nicest place I have been to out of all the brain injury units around.” Families told us they could visit whenever they wished and there were various areas in the building they could use if they wished to spend time alone with their relative.

Throughout the inspection we observed staff supporting people in a caring, respectful and dignified way. We noted from the care records that people were asked their preferred gender of staff to provide support. Staff were inclusive and ensured people knew there was an inspection taking place and they could therefore have the opportunity to speak with us during the day.

The staff we spoke with demonstrated an excellent understanding of the specific needs of each of the people living there. They told us one of the aims of the service was to support people to develop skills to promote their independence. This was important as some people were aiming to live more independently in the community. To support this, staff told us they encouraged people to make choices in all aspects of their daily living. Staff also encouraged people to look at how they engaged with others. We observed a member of staff discreetly encouraging a person to reflect on and change something they had done that could have offended other people. We noted later the person had made the change. We spoke with the person who was aware that they needed to change some of the ways they communicated with people so they would not be vulnerable in the community.

We observed staff communicating with each person in a way the person understood and responded to. We noted from the care records that each person had a detailed plan that focussed on how they communicated. Before we spoke to some people staff explained how they communicated. For example, one person used a combination of words and gestures and we were prepared for this before we spoke with the person.

People told us they were involved in planning their care. They said there was a weekly meeting and their schedule for the next week was planned. We could see that weekly schedules were displayed in each person’s bedroom and in a communal area if people agreed. Some people experienced short term memory loss so by having the schedules displayed meant people could access it at various points in the building. Each person had a person centred plan and they were involved in reviewing these each year.

Families told us they were included in their relative’s care. One family member said, “I am very involved in the care. The staff make sure I’m involved.” Families said staff promptly communicated if there were any changes to their relative’s health care needs. A family member told us the staff took into consideration their work schedule and home commitments when completing the weekly planner for their relative. They did this to optimise the time the family could spent together.

One of the people living there had no family representation. The registered manager had organised advocacy support for the person.

Good

Is the service responsive?

Our findings

People we spoke with said the support they received at Walker Lodge was based on their needs and what they agreed to as part of their overall person centred plan and weekly schedules. Some people had legal restrictions in place that they were not happy about but understood this was something the staff were not in a position to change. They said the staff supported them well and promoted their independence even with the restrictions in place.

People told us they developed a weekly schedule each week with staff and said these schedules were adhered to. Even if they did not feel like participating in a planned activity staff encouraged them to adhere to the schedule. The registered manager had substantial experience of working with people with acquired brain injury (ABI) and explained that people with a brain injury require structure and organisation so that they have a clear routine to work with. Therefore the weekly planners were an important part of how staff supported people so each person knew what they were doing each day. This approach was in accordance with national clinical guidelines in relation to rehabilitation following an acquired brain injury. The weekly schedule included a room organisation activity. This meant staff supported people to tidy and clean their bedrooms and organise their belongings. There were no cleaning staff employed at Walker Lodge and all the bedrooms we looked at were clean, tidy and well organised.

The service had contracts in place with a range of therapists, including a drama therapist, speech and language therapist, physiotherapist and occupational therapist. The registered manager informed us that each person had a therapy budget and the type of therapy they received depended on their needs. For example, a person was being supported to develop skills to move to their own property so most of their therapy budget was spent on occupational therapy in order to prepare them for independent living. The impact and outcomes of therapy for were reviewed with the person and relevant others each month.

We spoke to the person who was aiming to live independently and they said staff were working with them to a find a property in the local area. The person wished to stay in the local community as they had developed relationships with local people and businesses. The person said, “They all know me around here and look out for me. If something happened they would ring here [Walker Lodge].” The person had a fob key so they could come and go from the home on their own. They told us they were receiving support from a therapist and staff to make their own meals. The person said staff were helping them with budgeting so they made their money last. We heard from staff that the work around budgeting was having a positive outcome as the person had developed a better sense of the need to budget and was more thoughtful before spending money.

There was a strong emphasis on people being part of the community. The people living at Walker lodge were at different stages of rehabilitation so some people were more engaged with the local community than others. Staff supported people in the community who were unable to go out alone. People did their own food shop at a supermarket with the support of staff. They also used local facilities, such as the library, local shops, pubs, cafes and restaurants. One person told us he used the computer at the library to look for college courses. Some people who lived at the home had formed friendships and often went out socially together. We also heard some people had gone on holiday together and were planning another holiday this year.

A family member informed us that staff were accommodating and supportive when they brought their relative to their home a couple of times a week. If the family member was busy or pushed for time then the staff accompanied their relative to their home in a taxi.

The care records we looked at reflected the level of person centred care people were telling us about and what we had observed. Each person had a person centred plan in place that they had been supported to develop and had involved key people in the person’s life. We noted these were refreshed annually. From what people and staff told us, staff were working towards supporting people to achieve their aspirations and goals outlined in the plans. The care records for each person also included a relationship map, a document titled ‘What’s important to me’ and another titled ‘A typical day’. Each person had a ‘One page profile’ in place that provided an overview of their support needs.

People living at the home and their families were aware there was a complaints procedure in place. We asked people how responsive staff were to any concerns or complaints they may have. Everyone told us that concerns were resolved quickly. They said they felt comfortable

Good

Is the service responsive?

raising concerns as the registered manager was approachable and listened to them. One person living at the home used email to raise any concerns with the registered manager. They said they received a prompt response to concerns raised. Family members also told us staff dealt with any concerns promptly. One family member told us, “If I say I’m not happy with something they look into straight away. They will even ring you later to say what they found.” They said the concerns they had were very minor but they just wanted the best for their relative.

The registered manager maintained a log of the complaints and we observed that complaints had been responded to in a timely way. The outcome of each complaint was recorded, including any further action taken. Staff told us any learning from complaints or changes as a result of a complaint was shared with them at handovers and/or staff meetings.

Good

Is the service well-led?

Our findings

People living at the home spoke well of the registered manager. Some people had lived there before the registered manager was employed over two years ago and they told us that positive changes had been made in the last two years. One person said, "It is a better set up and a happier place." Another person said, "You can go to the manager and things get sorted." People who lived at the home approached the registered manager periodically throughout the day of the inspection and we observed that they were given the time to express themselves and engage in conversation.

Family members we spoke with were pleased with how the service was run. They said the registered manager and staff were approachable and took the time to listen to what they had to say.

Equally, staff were very positive about the leadership and management of the home. A member of staff said, "The place is massively better since the new manager came. She gets things done." Another member of staff described the service as "much more organised" with "strong leadership". We also heard from a member of staff that, "The manager is brilliant. She listens to your views and if you are unsure of anything she will explain it to you."

Staff said the manager promoted a person-centred culture and the unique needs of people was taken into account in the way they worked each day. In addition, staff told us an open and transparent culture was encouraged within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. They were confident the registered manager would be supportive and protective of them if they raised concerns.

We asked the registered manager about the quality assurance system in place to monitor performance and to drive continuous improvement, including feedback from people who lived at the home and their families. We were provided with a report to show how the service had been assessed in March 2014 by Headway against the required standards for Headways' Approved Provider Scheme. The service met the standards and was successfully granted the status of a Headway Approved Provider for a period of two years. Headway is a UK-wide charity that works to improve the life of people with an acquired brain injury.

Arrangements were in place for people, families and staff to provide feedback about the service. We looked at the annual satisfaction survey for 2013. This covered all areas of support provision, including the environment. An action plan was developed following analysis of the feedback. In 2014 the service was involved in a joint survey with Headway. The registered manager told us the return rate for the questionnaires was lower than in 2013. People living at the home and families said the questionnaire was too big. Based on the feedback a new questionnaire format had been developed for 2015.

People who lived at the home and their families were actively involved in the recruitment of new staff. The registered manager told us about a recruitment day last year where potential new staff spent a day at the service. People, families and staff provided feedback on how they interacted and engaged and we were informed that the feedback was taken into account when appointing new staff. The registered manager highlighted that the process was beneficial to people living there as some people remembered the appointed staff when they started working there.

Key worker meetings were held on a monthly basis. A key worker is a member of staff with responsibility for ensuring a person's support is provided in accordance with their support plan. Staff told us the key workers got together with each person to discuss their support plans and review their goals. Sometimes this discussion took place informally as part of an activity in the community. We could see from the care records that these discussions were recorded.

Monthly staff meetings took place. We looked at the meeting minutes from November 2014. We could see that the staff were provided with feedback from the operational team meeting. In addition, staffing matters, health and safety, the Mental Capacity Act (2005) and Care Quality Commission (CQC) were discussed. The registered manager advised us that the staff team meeting for December 2014 was replaced with a social event for people living at the home and their families.

The registered manager explained that a weekly report was produced for the provider. We were shown one of these reports and noted that it took account of all visitors to the service, hours of support provided, new referrals, new admissions, staffing issues, complaints and incidents. The

Good

Is the service well-led?

quality team for the provider reviewed this report in order to identify and emerging themes or patterns. They contacted the registered manager if they had any queries or identified any concerns.

A full service audit of the home took place on a quarterly basis. The registered manager and senior staff completed the audit. We looked at the audit from January 2015 and noted it was aligned with the CQC current methodology using the five questions. An action plan was developed where concerns were identified. We saw the action plan for October 2014 and could see that the actions had been addressed. The operational manager reviewed the quarterly audits. The findings from the audit were discussed at staff meetings.

A process was in place for keyworkers to audit the care records another keyworker was responsible for. We saw these audit documents in the care records and action plans had been developed if the care records needed to be improved upon.