Black Country Housing Group Limited

New Bradley Hall

Inspection report

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West Midlands
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Tel: 01384278689

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

New Bradley Hall is registered to provide accommodation for 31 people who require nursing or personal care. People who live there have health issues related to old age and/or dementia. At the time of our inspection 29 people were using the service. This was the first inspection of this service since they had changed provider to Black Country Housing Group Limited in February 2015.

This unannounced inspection took place on 16 September 2016.

The service had no registered manager at the time of our inspection. The Head of Service was overseeing the day to day running of the service as interim manager. Interviews had taken place for a registered manager and we were informed that a job offer had been made to the successful candidate. 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.

Medicines within the service required more comprehensive checks to be completed and guidance for staff in their administration to be implemented. Staff were trained in how to protect people from abuse and harm; they knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risks to people were assessed and guidance was available for staff to follow to ensure they were protected from harm. Records in relation to incidents that occurred did not always clearly demonstrate the outcome or outline any learning or changes to practice as a result. Staffing levels were adequate; however people's increasing levels of dependency were due to be given further consideration to ensure their changing needs could be met effectively. The recruitment process was robust and the provider was as sure as possible, that staff employed were suitable and safe to work with people.

Staff supervision was regularly provided and staff had access to the support they needed when they needed it. People's consent was sought by staff before supporting them and consideration was given to their mental capacity to make informed choices. Training on offer from the provider was complimented by staff in terms of variety and availability. People enjoyed their meals and were supported by staff to eat and drink enough to keep them healthy. Staff accessed input from health care professionals for people when they needed it.

Staff were caring and kind towards people, displaying friendliness and warmth when interacting with them. People were happy with the way staff communicated with them and the information they were provided with. Staff were respectful towards people and maintained their privacy and dignity whilst supporting them. People were encouraged to remain as independent as possible by staff. Information for people in relation to local advocacy services needed to be sourced.

People were actively encouraged to participate in activities that were of interest to them with support from staff. People were clear about how to make their views known and information was available about how to

make a complaint. People and/or their representatives were involved in planning and reviewing their support needs.

The service had no registered manager at the time of our inspection, but people were positive about the leadership of the service and expressed their confidence in the interim manager's abilities. The provider's quality assurance systems were not always effective in identifying issues, including not consistently notifying us of events that occurred within the service. People's feedback in relation to the quality of the service was sought through a variety of meetings and surveys. The providers had developed strong links with the local community; they were open and inclusive about their future plans for the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines within the service required more comprehensive checks to be completed and the development of guidance for staff in their administration.

People were cared for by staff that had the skills and knowledge to protect them from harm.

Staffing levels were adequate; however people's increasing levels of dependency were due to be given further consideration to ensure their changing needs could be met effectively.

Is the service effective?

Good

The service was effective.

Staff were supported with their development through a range of supervision, a comprehensive induction and training.

People's human and civil rights were upheld and staff took appropriate action if people did not have the capacity to make decisions.

People's nutritional requirements were regularly monitored, well understood by staff and appropriately catered for.

Is the service caring?

Good

The service was caring.

Staff communicated with people respectfully and involved them in making decisions about all aspects of their care.

People spoke positively about the caring and kind nature of the staff.

People were treated with dignity and staff respected people's right to privacy.

Is the service responsive?

Good

The service was responsive.

A good variety of activities was available within the service and where possible centred on people's interests.

People were clear about how to make their views known and information was available about how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's audits and checks were not consistently comprehensive and failed to identify a number of issues we found.

People and staff were positive about the leadership of the service

Feedback from stakeholders was actively sought by the provider.

New Bradley Hall

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 16 September 2016 and was unannounced. The inspection was undertaken by one inspector.

We liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG and local authority are responsible for buying local health care and checking that services are delivering the best possible care to meet the needs of people. We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. We looked at notifications that the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

During our inspection we spoke with five people who used the service, two relatives, the cook, a housekeeper, five members of staff and the interim manager [Head of Service]. We observed the care and support provided to people in communal areas. Not all the people using the service were able to communicate with us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. These included reviewing three people's care records, three staff recruitment records and five people's medication records. We also looked at a range of other records used for the management and monitoring of the quality of the service, for example, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe and trusted staff. They told us, "Its good here, they [staff] always make sure I am safe when they move me" and "Yes its very safe here, the staff make sure of that". Relatives we spoke with told us they had no concerns about their family member's safety.

People told us they were happy with how staff supported them with their medicines. They told us, "I get my medicines just as I like them, on time" and "I am happy for them [staff] to look after my medication". We reviewed how medicines were being managed within the service. We looked at five medicine administration records (MAR) in depth. We found discrepancies in the levels of medicines in stock for two people and we were unable to evidence that these medicines had been administered as outlined in their MAR. We saw that not all boxed medicines [medicines not contained in blister packs] were counted in as new stock arrived, this would potentially prevent accurate checks against the MAR being possible. We found that no guidance had been made available to staff about when and why 'as required' medicines should be provided to people. We also saw that staff were failing to record the reasons why they were providing people with their 'as required' medicines. This meant that people may be receiving their 'as required' medicines inconsistently, due to a lack of guidance available and/or recording by staff.

Medicines were regularly audited by staff but the audits we reviewed had not been fully completed. For example, the audit tool used by the provider asked whether protocols or guidance was in place for 'as required' medicines, but this question had been overlooked on all of the audits we reviewed. People had their medicinal skin patches for pain relief applied accurately and at the correct intervals. Staff received training in relation to the safe administration of medicines and had their competency checked upon completion of the initial training and any future updates. A staff member told us, "After completing medicines training you are observed providing a minimum of ten people with their medicines, or even more if necessary to make sure you are doing it safely". The ordering and storage of medicines was found to effective.

Staff were clear about their responsibilities for keeping people safe and protecting them from avoidable harm. They were able to describe to us the different kinds of abuse people may be exposed to and what action they would take if they suspected someone was at risk, including the reporting procedures. Staff told us, "I know how to identify abuse, seeing someone fearful or noticing any changes in their behaviour; I would try to get them to talk to me or report my concerns" and "You have to look out for bruising, mood changes and always reassure them and try to get the person to talk if possible". Staff received a variety of training in how to protect people from abuse and avoidable harm, for example, moving and handling techniques and infection control. The contact numbers and information on the local safeguarding authority was displayed on communal noticeboards.

Potential risks to people were effectively assessed in relation to their individual health and support needs. Records detailed how people's health risks should be managed to maintain their safety and wellbeing. For example, one person's moving and handling ability fluctuated so their risk assessment outlined how staff should reassess the level of assistance the person required on each intervention; various equipment that

was suitable for use by staff was outlined so they could support the person safely. Staff we spoke with were aware of this guidance and the need to re-evaluate the person's level of ability on each occasion. A staff member said, "We use risk assessment to protect people and use equipment like sensor mats if it is an identified need". Staff were able to describe people's individual risks and how these were minimised by their interventions, for example, providing thickened fluids to reduce a person's risk of choking. Records were updated as changes occurred and reviewed periodically.

Staff were able to describe how they would deal with and report any incidents or accidents that occurred. We reviewed the provider's records in relation to incidents that occurred within the service. The documentation we saw did not clearly demonstrate the outcome of all incidents or allow for any learning or changes to practice to be clearly outlined. We saw that one record was incomplete that related to an incident in July 2016. The signing off, review or action taken of incident forms by management was not always clear or complete. This meant that any investigation or analysis of incidents may not be comprehensive, encourage learning or the identification of trends. Staff told us that they did receive information and updates about incidents that had occurred, in meetings and daily handovers.

The provider had a fire safety risk assessment in place with clear procedures in the event of an emergency evacuation. Staff understood what the evacuation procedures were in the event of an emergency. One person told us, "The fire alarm gets tested every Wednesday; I know it's very safe here". Tests of the fire safety equipment were carried out regularly to make sure it was in good working order and fire exits were clearly sign posted. Regular checks and audits of the safety of the environment were routinely undertaken.

People told us there were sufficient staff available to support them. People said, "Well, staff we could always do with more, but there are enough to be carrying on with" and "They come when I call them". A relative told us, "They [staff] come fairly quickly when [person's name] calls them using the buzzer". We observed that there were enough staff available to meet people's needs in a timely manner on the day of our inspection. The registered manager told us that staffing levels were regularly reviewed based upon people's needs and level of complexity or as more admissions were taken. We reviewed the dependency tool being utilised, however it was difficult to see how this clearly informed the levels of staffing and rotas. For example, we saw that in recent weeks some people's needs had increased in terms of needing increased pressure relief or more assistance with moving and handling but no allowance had been made for this on the rotas, particularly at night. Staff we spoke with told us, "Staffing is up and down but agency staff we use are regular and pretty good", "It can be a rush sometimes, which is not ideal. There are only two staff on at night so if staff are attending to someone who needs two staff to support them then there is no one on the floor to look after other people" and "It is getting harder to get everything done, lots of people have deteriorated and now have more complex needs". All the staff we spoke with told us that at present the staffing levels and people's increasing needs were manageable and they were able to provide the care that people needed; but they did express their concern about the future if staffing remained static. We discussed our findings and staff concerns with the interim manager who told that had planned to review staffing levels due to a very recent increase in one persons dependency levels. The provider had numerous staff who had worked at the service for many years, which gave people consistency and increased familiarity with those who cared for them.

The provider had effective recruitment processes in place. All the appropriate checks were undertaken including two references and a Disclosure and Barring Service (DBS) check. A DBS check helps employers make safer recruiting decisions and minimises the risk of unsuitable people being employed. Staff we spoke with confirmed that they had been asked to provide satisfactory evidence that they were safe to provide peoples' care before commencing in their role.

Good

Is the service effective?

Our findings

People told us that they felt well looked after and that staff were competent. They told us, "They [staff] know what they are doing, they are very good and care for me well" and "If I want anything they do it, they [staff] are marvellous and yes they are competent". A relative said, "They know their stuff, they provide the best care". Staff told us that they received training that developed their skills in order to meet people's needs effectively. They said the training they had received since the new provider had taken over the service had been more varied and they clearly valued the opportunity to receive more training. Comments included, "The training is constant and they clearly want us to be well educated", "The training is of very good quality and thorough; there is lots of classroom training which allows for interaction which I find helps me to learn better" and "We have had some really good training and more of it since they [provider] took over". We saw that training provided was varied and specific to the needs of people that were being cared for.

Staff told us they received regular formal supervision periodically but could also access the support they needed at any time. Staff said, "I have supervision with a senior about once a month to discuss my training needs and any problems", "I have a really good supervisor and we meet regularly, I can ask them anything, they are very supportive" and "I can address any concerns I have in supervision and I get feedback if I have raised anything previously". We saw that the supervision structure for staff was clear and the interim manager checked each month to ensure it was working effectively.

Staff were provided with an induction when they started working at the service. They told us they were provided with an opportunity to shadow more established staff and that they had felt confident when fully commenced in their role. A staff member stated, "I had an in-depth induction, which included supervision, reviews and shadowing". The service had implemented the care certificate which sets fundamental standards for the induction of adult social care workers.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People told us and we observed that people were not restricted and that their consent was actively sought by staff before assisting or supporting them. They said, "They [staff] always listen to me and ask me before they support me in anyway" and "I am asked everything, they [staff] don't just make assumptions. I decide what happens". Staff had received training and updates in relation to the MCA and the DoLS. They were able to demonstrate an understanding of the need to consider people's ability to give consent and what may be considered as a restriction of their liberty. Records showed that people's mental capacity was considered and assessed when necessary. At the time of our inspection the provider had made applications to the supervisory body

to deprive people of their liberty, but none had been authorised at the time of our inspection.

The provider had effective systems in place to ensure that relatives and/or representatives acting on behalf of people in relation to health and/or finance issues, through a Lasting Power of Attorney (LPA) were clearly identified. This included acquiring a copy of the legal documents to confirm this. This meant that the provider was keen to ensure that people's health and financial welfare was considered through the appropriate channels.

People said they had 'plenty of choice' of food on offer to them. They told us, "You get lots of choices here, food wise. You can have another choice off the menu, they cater for everything", "If I don't like what's on the menu, they do me something else; the foods really nice here" and "They always ask me what I fancy, the food's lovely". We observed that staff went to each person telling them what was on offer for lunch and supported them to make a choice. A staff member told us, "You can't fault the food it's all good and homemade; people have a lot of choice". Following feedback from a meeting held with people the provider was in the process of arranging pictorial menus alongside written ones. We saw at lunchtime that the food on offer was homemade, smelt and looked appetising and was adequate in terms of nutrition. We observed lunch to be well-organised; with those people needing assistance or in their rooms receiving their meal being assisted if necessary in good time. We saw that people had drinks within their reach throughout the day.

The cook and staff were knowledgeable about people's individual dietary requirements, such as those people requiring soft or pureed meals if they had been assessed as at risk of choking. The cook told us. "I meet with each person individually and ask them about their likes and dislikes, which are recorded in the communication book in the kitchen. We cater for all diets, including any cultural, diabetic or gluten free ones". Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met. We observed a staff member supporting one person to eat as independently as possible by loading up their fork with food, which they were having difficulty with and then handing the person back the fork to complete the process. The person consumed a good amount of food as a result. We saw that people's weight was regularly monitored and nutritional assessments were completed and appropriate care plans outlining how these needs should be met were in place. Where the need for specialist dietary advice was required; we saw that referrals had been made to the appropriate external health care professionals. We saw that people were asked regularly for their opinion and thoughts on the menu content at meetings that were held.

People's health and well-being was supported by staff through regular monitoring and where required, referrals being made to health care professionals. One person told us, "They [staff] fetch the doctor or ambulance if you need it. They book me into see the doctor if it's not urgent, who comes in each week". Relatives spoken to said they were confident that all their family member's health needs were well catered for. Records we reviewed contained information for staff in relation to managing peoples' health conditions day to day, for example, pressure area care to maintain good skin health. Staff we spoke with understood people's health care needs and demonstrated they knew how to support them should they become unwell. We saw that referrals were made to external healthcare professionals on behalf of people, for example to district nurses.

Good

Is the service caring?

Our findings

People told us of the caring and kind approach of the staff supporting them. The comments they made included, "I am very happy here, they [staff] are so good", "The care here is wonderful, they [staff] can't do enough for me", "The staff here are excellent , I can't say a thing wrong about them" and "They [staff] are marvellous, everyone's so helpful, they are all so good". Relatives were equally complimentary saying, "The staff are wonderful, they just get on with it" and "They are very caring staff, they are brilliant". We saw that people were relaxed around staff and were responded to with warmth and friendliness.

People told us that they were comfortable, had the freedom they desired and felt listened to. They told us, "They [staff] are like family to me" and "They [staff] always listen to me and they always make time to talk to you. They know me well". We saw that staff frequently checked on people's well-being by asking them if they were comfortable or if they needed anything. We observed a relaxed atmosphere at the service, with staff that supported people's social interactions with each other. People told us that their relatives and friends could visit freely whenever they liked. One person said, "They [family] can come and go as they please". Many of the staff had worked at the service for several years which had enabled people who lived there to build meaningful and caring relationships with the staff. Staff we spoke with told us they enjoyed supporting the people living there and knew their interests and what they liked to do; we observed people enjoying staff company and chatting with them with real familiarity. Staff told us, "We know people really well and support them to have the life they want to live, as best we can" and "I love working here and supporting these people". □

People were encouraged to express their views and be involved as much as possible in making decisions about support needs. They told us, "They [staff] have talked to me and involved me in my care planning" and "Oh yes I am involved in deciding everything that happens to me". Relatives said, "I have attended meetings and all the care plans were discussed with us" and "They [staff] involve us and [person] as much as possible". We observed people being supported to make a variety of decisions about a number of aspects of daily living during our inspection, for example what activities they wanted to get involved in.

People, their relatives and visitors told us they were happy with how they were communicated with and the information they received. We saw that care plans described how best people should be communicated with. We observed that staff were patient and took the time needed to ensure that people understood what was said to them. Each person was provided with a 'welcome pack guide' when they were admitted which outlined what they could expect from the service.

The interim manager and staff told us how they would support people to access independent advice or an advocate if they required this. No information was available about local advocacy services, but the interim manager told us they would source more leaflets and display them. No one on the day of our inspection had the need to access advocacy services.

People told us staff communicated with them using respectful language and supported them in a dignified manner. The care they received was delivered in a respectful and dignified manner. They told us, "They

[staff] are always talking to me with respect. When they are helping me to wash and dress they shut the curtains and make sure I am warm and cover me up" and "They [staff] knock the door and wait to be asked to come in, they don't just barge in". Staff were clear about how to support people to maintain their independence and the importance of providing respectful, dignified care. They told us, "It's about being there for someone who can't support themselves and giving them the opportunity to always try to do the small things" and "I do the practical things like shutting the door and curtains, don't allow other staff to walk in and out when giving someone personal care. I support the person to have the time they need to be alone, let them have time in their room, maybe to lay down or just have some quiet time". We observed that staff were respectful towards people and where possible encouraged them to try to do as much for themselves as possible. People who required support to use the toilet were spoken to discreetly in communal areas and guided carefully by staff to maintain their dignity.

Good

Is the service responsive?

Our findings

People's care was planned and reviewed with their input and/or their representative's involvement where possible. They told us, "They have talked to me and involved me in my care planning" and "I have set out with them [staff] what I would like and how I like things done, they know me very well by now". Records we reviewed evidenced that regular reviews of people's care were undertaken with them or their relatives. Care plans were personalised with details of people's likes, dislikes and preferences. Staff demonstrated they knew people well and gave examples of their particular likes and dislikes, including their little 'quirks'. Examples included describing certain material/personal belongings that people, when seated in communal areas, liked to have near to them and their awareness of the people who preferred their own company. A staff member said, "The care we provide is centred on the person, what they want, how they like things done and what they like to do".

People told us that they enjoyed the activities on offer and that they could choose what they wanted to do and staff would support this. One person told us about the work they did in the gardens, and that they had particular storage space outside that was allocated only for their use. We observed that people were occupied and appeared content just sitting in each other's company or were supported by staff to participate in other activities such as, dominoes or looking at picture books. People were asked their thoughts about the activities available to them, "I go out to the village and the staff help me do the things I like, I am happy with what I get to do", "The entertainment is always very good" and "I get involved in most things going on". A relative said, "They have singers and activities and they [staff] try to involve [person] as much as possible". The provider has recently taken on a volunteer and an apprentice who also assisted people to participate in activities of their choosing. In the records we reviewed we saw a document called 'Who am I', which contained a wealth of information about people's life, family and employment history as well as their interests or hobbies. Staff told us, "There is always lots of things going on that people can enjoy" and "We do our best to get people involved, we know what interests them". People had access to the local community and went out to the village and on occasion went out to the pub for lunch. This meant that activities were on offer which supported people to follow their interests and be meaningfully occupied.

People were encouraged and supported by staff to personalise their rooms and display items that were of sentimental value or of interest to them. A relative told us, "[Person] has all her photos up that she wanted; she is comfortable and it's very homely". People described to us how staff supported them to maintain relationships with their friends and families in a number of ways, including taking telephone messages for them when they were not available and being welcoming towards their relatives and visitors.

People's cultural and spiritual needs were considered as part of their assessment. We saw in records that where a need was identified in relation to, for example religion, the provider ensured support was given to support the person to follow this in line with their wishes. No one we spoke with on the day of our inspection had any particular cultural or spiritual needs. Staff were clear about how they would support people to meet any more diverse needs.

We saw that the provider was keen to expand staff knowledge in relation to person centred care, by

arranging a number of training events for staff to attend. Staff told us they were kept updated about peoples changing needs through meetings, handover and communication books. A staff member told us, "The communication is good here, we know when anything's changed with people through handover or it's written down if you've been off". Our observations throughout the day showed that people were responded to appropriately when they needed support by staff who knew their needs well.

People we spoke with knew how to make a complaint. One person told us, "I have never had to raise a complaint but know I can and it would be sorted". We reviewed how the provider dealt with complaints. One relative told us that they had had need to raise a concern with the provider. They told us, "We raised a concern and [interim manager's name] sorted it all out to our satisfaction, she made things right". The service had a complaints procedure which gave people the guidance they needed about how to make a complaint and whom they should contact. We found that overall the provider acknowledged, investigated and responded to each complaint received in a timely manner and in line with their own policy. Staff knew how to direct and support people to make a complaint. A staff member said, "I would listen to the person who was unhappy and ask them if they wanted me to report it and if so notify the person in charge or tell them to complete a form". I would report it to my senior and get them to take the details to pass it on to the manager, or send them to the manager straight away if they were available". We saw that 'tell us how we are doing forms' were made freely available for people or their visitors to complete and submit them anonymously if preferred. These allowed people to raise a concern or alternatively give a compliment. The complaints we saw were minor and did not allow for any changes to practice or learning, although the interim manager said, "We always consider whether we need to change or improve anything we do when we get complaints".

Requires Improvement

Is the service well-led?

Our findings

The provider undertook a number of regular checks and audits to assess the quality of care and safety of the service provided. However these systems did not consistently identify the issues we found, for example with medicines management and incident recording. We also noted that two incidents that had occurred at the service where a person had sustained a serious injury had not been reported to us. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. The interim manager was aware of their responsibilities to report certain events that had occurred within the service. We raised the issue of the unreported events with them and they agreed this had been an oversight and they would provide any notifications retrospectively as necessary to us. Records of audits and checks being completed that we reviewed varied in the quality of their analysis and evidence of actions taken. This meant that some aspects of the provider's quality assurance process of the service were not robust.

The service had no registered manager at the time of our inspection. The Head of Service was overseeing the day to day running of the service in the interim. Interviews had taken place for a registered manager and a job offer had been made to the successful candidate. People told us they knew who the interim manager was and were positive about how they had been kept updated in relation to a new manager being appointed. They commented on the management of the service, saying, "It's very well run here, you can talk to any of the staff or managers", "The place is well managed and I am looking forward to us having a new more permanent manager, it's fantastic living here" and "It's all run so smoothly".

Staff spoke positively about the quality of the leadership within the service. They said, "[Interim manager's name] lets us know exactly what's going on, she's really good" and "I think its brilliant here, the managers are good and I have worked for other companies and they weren't anywhere near as nice". Staff told us that there was an open culture within the service and they felt comfortable to raise any issues with the interim manager. They said that management were supportive and available to them when they needed support.

Staff told us they felt supported in their role through meetings and supervisions. We saw that a range of systems of communication were in place within the home, for example handovers. We found these were effective at ensuring staff had the information they required to provide people with the care and support they required. Staff told us they were clear about their role and what was expected of them and that they were encouraged to express their views and make any suggestions which could improve the quality of the service. Staff described how they would report any concerns they had if they learnt of or witnessed bad practice. The provider had a whistle blowing policy, for staff to refer to and this detailed how staff could report any concerns.

The interim manager had recently incorporated a 'care delivery monitoring system' to be completed by senior staff to enable them to observe and record staff competency whilst undertaking specific elements of care, for example administering medicines. The interim manager told me this was currently being embedded into routine practices for checking on quality of care delivery and staff skills within the service.

People's and relative's feedback was sought in regular meetings and through surveys distributed

periodically by the provider. A relative told us, "They [provider] have meetings and people can always have their say". We saw that surveys sent out in August 2016 were awaiting analysis. We reviewed those that had been returned and found around a third of them contained some less positive about comments in relation to the availability and level of staffing. The interim manager told us they would review these and address them accordingly, alongside revisiting the dependency level of people using the service. This meant that the provider offered stakeholders a variety of ways to share their experiences and opinions about the service.

The provider had developed strong links with the local community. The interim manager discussed the plans of the provider to rebuild New Bradley Hall in the same grounds, with some increase in the number of beds. We saw that the current building had had some alterations and improvements made by the provider when they took over. However, long term the decision had been made to completely rebuild in order to give people a more modern, purpose built living environment. A relative told us, "We met the provider; they have done what they can inside in the meantime before the rebuild. We have been to the design and consultation meetings about the new building. People have been fully involved however possible". Staff confirmed they had been kept informed of all developments. A staff member said, "Most of us attended the consultation meeting, they discussed everything and you could ask questions". The provider held consultation and planning meetings for people, staff and local people, to discuss and plan how they will undertake the project with the minimum amount of disruption to all who may be affected. This meant that the provider was keen to involve and include the local community in its future plans for the service.