Pendle Residential Care Limited

Calder View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Calder View on 16 and 17 May 2018.

Calder View is a 'care home' which is registered to provide care and accommodation for up to six adults with mental ill health. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Nursing care is not provided at Calder View. At the time of our inspection five people were using the service.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In the absence of the registered manager the provider had made interim arrangements for the management of the service.

At our last inspection in March 2017 the service was rated Requires Improvement. This was because the provider had failed to ensure there were safe staff recruitment processes. This was a reoccurring breach of the regulations. We therefore issued the provider with a Warning Notice to make improvements. Recommendations were also made on improving medicine management processes and promoting healthy eating. At this inspection we found action had been completed to make improvements.

During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the evidence to support the rating of Good.

We found there were management and leadership arrangements in place to support the effective day to day running of the service. The registered manager had made a number of improvements and the provider was monitoring the service.

Staff recruitment procedures had improved. Robust processes were in place to make sure all appropriate checks were carried out before staff started working at the service.

There were enough staff available to provide care and support; we found staffing arrangements were kept under review.

People told us they felt safe at the service. Staff were aware of the signs and indicators of abuse and they knew what to if they had any concerns. Staff had received training on supporting people safely and abuse and protection matters.

Systems were in place to maintain a safe environment for people who used the service and others.

We noted some of the windows were in need of attention, however we found the provider had taken action to make improvements.

Arrangements were in place to gather information on people's backgrounds, their needs, abilities and preferences before they used the service. They were encouraged to visit, to experience the service and meet with other people and staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and processes at the service supported this practice.

We found people were effectively supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to. People had been supported to increase their awareness of their wellbeing and health care needs.

People were satisfied with the meals provided at Calder View. People were actively involved with devising menus, which meant they could make choices on the meals provided. They had been given information on healthy eating and balanced diets.

People made positive comments about the care and support they received from staff. We observed positive and respectful interactions between people who used the service and staff.

Each person had a care plan, describing their individual needs and choices. This provided guidance for staff on how to provide support. People had been involved with planning and reviewing their care.

People's privacy, individuality and dignity was respected. They were supported with their hobbies and interests, including activities in the local community and keeping in touch with their relatives and friends. People had opportunities for skill development and confidence building.

There were processes in place for dealing with complaints. There was a formal procedure to manage, investigate and respond to people's complaints and concerns. People could also express concerns or dissatisfaction during their care reviews and during residents meetings.

There were systems in place to consult with people who used the service and staff, to assess and monitor the quality of their experiences. Various checks on quality and safety were completed regularly.

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.

Processes for staff recruitment would include the completion of relevant character checks. There were enough staff available to provide people with safe care and support. Staff were aware of safeguarding and protection matters.

Processes were in place to maintain a safe and clean environment for people who used the service.

People were safely supported with their medicines.

Is the service effective?

Good

The service was effective.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was supported and they had access healthcare services when necessary.

People were supported to eat healthily; their preferred meal choices were known and catered for.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

People made positive comments about the supportive and caring attitude of staff. We observed positive and respectful interactions between people using the service and staff.

Staff were aware of people's individual needs, backgrounds and personalities, which helped them provide personalised support.

People were supported in a way which promoted their dignity, privacy and independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Processes were in place to monitor, review and respond to people's changing needs and preferences.

People had opportunity to maintain and develop their skills. They had access community resources, to pursue their chosen interests and lifestyle choices.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

Is the service well-led?

Good

The service was well-led.

There was a management team providing effective leadership and direction.

Staff were knowledgeable and positive about their work. They indicated team work was good and the managers were supportive and approachable.

There were processes in place to monitor and check the quality of people's experience of the service.

Calder View

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 checked 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.

We visited Calder View on 16 and 17 May 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of one adult social care inspector.

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Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, commissioners of care and care coordinators. The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent some time with people, observing the care and support being delivered. We talked with four people who used the service about their experiences of their care. We spoke with three support workers, a team leader, the registered manager and the area manager. We also talked with a visiting advocate. Advocates are independent from the service and can provide people with support to enable them to make informed decisions.

We looked at a sample of records, including two care plans and other related care documentation, three staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Good

Is the service safe?

Our findings

At our last inspection we found there was a lack of robust recruitment procedures for the well-being and protection of people who used the service. At this inspection we found improvements had been made and the staff recruitment procedures protected people who used the service. The provider had introduced additional protocols and checking systems, which were underpinned by a revised staff recruitment policy. We reviewed the recruitment records of the two newest recruits. The recruitment process involved candidates completing a written application form and attending a face to face interview. Character checks including, identification, references and qualifications and employment histories had been appropriately carried out. A DBS (Disclosure and Barring Service) check had been completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. All new employees completed a probationary period to monitor their work conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

People were supported with the proper and safe use of medicines. At our last inspection we made a recommendation on medicines storage and checking systems. At this inspection we found improvements had been made. Although there were no controlled drugs, which are medicines which may be at risk of misuse, safe storage facilities for such medicines were available. Care records included records of people's prescribed medicines. Action had been taken to involve people more with their medicines. There were risk assessments and care plan instructions for staff to follow on supporting people safely with their medicines. People spoken with were satisfied with the arrangements in place for support with their medicines. One person told us, "I get my medicine on time and I am aware of them all."

The medicines administration records (MAR) we reviewed were appropriately kept, complete and accurate. We found there were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. We noted some protocols were lacking in specific detail. However during the inspection, the team leader proactively up-dated the protocols to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered.

The service had medicine management policies and procedures which were accessible to staff. Records and discussion showed staff providing support with medicines had completed training. There were processes in place to assess, monitor and review staff competence in providing safe and effective support with medicines.

We checked how the service protected people from abuse, neglect and discrimination. All the people we spoke with indicated they felt safe at the service. Their comments included, "Yes I feel safe living here", Things are fine" and "They never shout or tell me off." We talked with an advocate who considered the person they were representing was safe at the service. Prior to the inspection, we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We found systems were in place to record and manage safeguarding matters. Action had been taken to liaise with local the authority and other agencies in relation to allegations and incidents. We discussed with the registered

manager their responsibilities to monitor any safeguarding incidents and accidents at the service, to ensure there was a proactive 'lessons learned' approach.

The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. Staff spoken with expressed an understanding of safeguarding. They were aware of the various signs and indicators of abuse, including physical abuse, financial abuse and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff spoken with were aware of the service's 'whistle blowing' (reporting poor practice) policy.

We reviewed how risks to people's individual safety and well-being were assessed and managed. Individual risk assessments and risk management strategies were in place to guide staff on minimising risks to people's wellbeing and safety. The risks assessed included, diet and food, behaviours, relationships, mental health, physical health, risk of suicide, self-harm, accessing the community, cooking and support with financial matters. Processes were in place to review and update individual risk assessments. We noted one person's risk assessments had not been reviewed in accordance with the provider's three monthly timescale. However, the team leader took action to review the risk assessments and improve the electronic alerting system during the inspection. People had personal emergency evacuation plans. This meant their specific support needs in the event of fire had been identified and planned for. Staff spoken with were aware of people's individual risk assessments and said they had access to them. One support worker described the specific strategies used to positively and safely support an individual in the community.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. People spoken with did not express any concerns about the availability of staff at the service. Staff spoken with considered there usually enough staff available to provide safe support. We were told staffing levels were flexible in response to people's needs, lifestyles, appointments and activities. Arrangements were in place to provide ongoing management support, including on call systems for evenings and weekends.

Processes were in place to maintain a safe environment for people who used the service, visitors and staff. We found regular health and safety checks had been carried out and action taken to rectify matters. Records showed arrangements were in place to check, maintain and service fittings and equipment, including gas safety and fire extinguishers. The registered manager explained the improvements made for general maintenance and repairs. Fire drills and fire equipment tests had been carried out. There were accident, fire safety and contingency procedures available at the service. We noted people who used the service were involved with the fire safety procedures and evacuation drills. Arrangements were in place for the safe storage of records to promote confidently of information and data protection.

We reviewed how people were protected by the prevention and control of infection. The areas we saw looked clean and there were cleaning schedules and recording systems to maintain hygiene standards. Records and discussion indicated staff had completed training on infection control. There was an infection prevention and control audit process, to monitor and maintain suitable hygiene standards.

Good

Is the service effective?

Our findings

We looked at the way people's needs were assessed and planned for, prior to them using the service. People were to be encouraged to visit the service, for meals and short stays. This was to support the ongoing assessment process and provide people with opportunity to experience the service before accepting a place. The registered manager said the admission process took into consideration the person's compatibility with people already using the service. One person told us, "They introduce any new people to us" another said, "I came to visit for the morning with staff.

The registered manager described the process of initially assessing people's needs and abilities before they used the service. This involved meeting with the person and completing a needs assessment, by gathering information from them and any relevant health and social care professionals. The service had policies to support the principles of equality and diversity, and these values were reflected in the care assessment and care planning process. This meant consideration was given to protected characteristics including: race, sexual orientation and religion or belief.

We looked at how consent to care and treatment was sought in line with legislation and guidance. During the inspection we observed staff consulting with people on their individual needs and lifestyle choices. They involved people in routine decisions and sought their agreement on when providing support. One person commented, "Within reason I can do what I want. We agree when we are going out. "People spoken with expressed an awareness of their care records and we noted they had signed in agreement with them. They also had signed individual contracts which outlined the terms and conditions of residence. "I sign in agreement with things; they ask all the routine questions," explained one person.

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

Processes were in place to assess people's capacity to make decisions and the specific support to be provided and this was kept under review. Policies and procedures were available to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with said they had received training on the MCA, they indicated an awareness of DoLS and the legal status of the interventions and agreements in place. Staff expressed an awareness of their role to uphold people's rights and provide care and support in the least restrictive way possible.

We looked at how people were supported to live healthier lives. People were offered the opportunity for and

encouragement with physical exercise. We noted some positive approaches around the promotion of healthcare awareness and general wellbeing. For example, there had been monthly theme topics around sleeping well and oral hygiene. There were displays on smoking and alcohol consumption and discussions groups on specific health matters had been introduced. People's medical histories and mental health conditions were included in the care planning process. There was a 'recovery star' approach in place to support people in actively sharing responsibility for identifying and managing their mental health care needs.

All the people we spoke with indicated they had access to health care professionals when needed and told us staff supported them with appointments. People said, "I have health checks and medical reviews" and "I have a check-up at the dentist and eyes tests at the opticians." The service was part of the 'Red Bag Scheme.' This was an information sharing initiative, to improve the transition process when people accessed healthcare services. There were 'hospital passports' to transfer and effectively share personalised healthcare and support details.

We checked how people were supported to eat and drink enough to maintain a balanced diet. At our last inspection we made a recommendation on supporting people with healthy eating. We asked people for their opinion of the meals provided at the service, their comments included, "The food is okay here," "We have some good food" and "I enjoy most of the meals." Records were kept of people's specific dietary needs, likes and dislikes. Processes were in place to check people's weight at regular intervals. This was to help monitor risks and support people with their diet and food intake. There was an informative display on healthy eating for people and staff to refer to. One person told us, "They have talked to us about heathy eating." The registered manager had introduced a visual prompt to help encourage people to monitor and respond to their own hydration needs.

The week's menu was on display; this had been discussed and agreed with people. One person explained, "We discuss and plan the menu during meetings and alternatives are always available." People also shared responsibility for shopping and cooking, some with staff support. Some did their own grocery shopping and made their own meals. We observed people making drinks and snacks for themselves during our visit. Staff had an awareness of nutrition and healthy eating. They described the support they provided people with in relation to food, diet, meal preparation and cooking.

We checked how people's individual needs were met by the adaptation, design and decoration of premises. People were satisfied with the accommodation and facilities available at Calder View. We found people had been encouraged and supported to personalise their rooms, by choosing colour schemes and bedding. One person explained that they been enabled to bring their own furniture with them. We noted parts of the premises had been redecorated and some new flooring fitted. There was a lounge, a lounge /games room and a dining kitchen. There was a garden area to the rear of the premises, with garden furniture, a smoking shelter and pet rabbits. We noted no progress had been made with replacing the windows. However we were shown evidence to demonstrate action had been taken to rectify this matter.

We reviewed how the service used technology to enhance the delivery of effective care and support. The service had internet access; this enhanced communication and provided access to relevant information. For example, sending and receiving e-mail messages and accessing the provider's policies and procedures. There was electronic care planning system which was used to assess, plan and monitor the delivery of care.

Records and discussion showed arrangements were in place for staff learning and development, to help them meet people's needs. On person said, "I think the staff are well trained." Processes were in place to support an initial induction training programme which included the completion of the Care Certificate. The

Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. One member of staff spoken with said they had commenced an initial induction programme and records were available to confirm others had completed induction training.

Staff spoken with described the training they had received and said that learning and development was ongoing at the service. We saw records of training planned for and completed and examples of certificates confirming that learning had been achieved. Staff were enabled to attain recognised qualifications in health and social care. Most staff at the service had either attained an NVQ (National Vocational Qualification) in care or were working towards a QCF (Quality and Credit Framework) diploma in health and social care.

Staff spoken said they received one to one supervisions with a member of the management team. We saw records of supervisions held and noted plans were in place to schedule supervision meetings. Processes were in place for staff to receive an annual 'competency framework' review of their work performance; this included a self-evaluation of their skills, abilities and development needs.

Good

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People spoken with made positive comments about the staff team and the care and support they received. They said: "I think the staff are good," "The staff seem to be caring" and "I know all the staff and I like all of them." We observed some tactful and respectful interactions between people using the service and staff. Staff showed sensitivity and consideration when responding to people's support needs and requests. One person said, "The staff are respectful; they are decent people. They treat me fairly well."

We found positive and meaningful relationships were encouraged. People told us how they were actively supported to have contact their family and friends. The service had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with. People spoken with knew who their 'keyworker' was and described aspects of the support they received from them. Staff indicated they had time to provide care and support, to listen to people and involve them with decisions. One person who used the service told us, "The staff are nice, they look after me. I can go to them with any problems, they listen." An advocate spoken with described how the person they represented benefited from the supportive approach from staff, which had resulted a mutually respectful relationship and a positive outcome.

People had support plans which identified their individual needs and preferences and how they wished to be supported. The information was written in a sensitive and person centred way. There were 'one page profiles' and 'pen portraits' which provided an overview of people's routines and expectations and how they wished to be supported. The information included their background histories, personal relationships, family contact, cultural heritage and spiritual needs. People indicated they had been actively involved in compiling their care plans and ongoing reviews. Their comments included, "They ask me what I want to do and involve me" and "I have a keyworker they came to do a review."

Staff spoken with knew people well and understood their role in providing people with person centred care and support. They were aware of people's individual needs, specific routines, preferences, backgrounds and personalities. They described how the provided support in response to their needs preferences and behaviours. Staff had received equality and diversity training. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences.

We reviewed how the service empowered and enabled people to be independent. We found the service was working towards constructively motivating and empowering people with day to day matters, as part of their ongoing development. Since the last inspection some people had progressed to more independent living. People spoken with described how they had been enabled to develop independence skills, by accessing the community resources and doing things for themselves and others. Their comments included, "I can do what I want," "I change the bed. I put the laundry in the washer" "I cook my own brunch" and "I do my own laundry and personal shopping." People expressed their views and opinions during daily discussions. They were routinely offered choices and encouraged to make their own decisions. Residents meetings were held

which provided the opportunity for people to make suggestions, be consulted and make shared decisions. People said, "Sometimes we have meetings we talk about what we are going to eat," "We talk about different things" and "They ask each of us if we have any thoughts on activities and proposed changes." We noted from the records of meetings that various matters had been raised and discussed. However we noted there was a lack of information to show how ideas, suggestions and agreed outcomes had been actioned. The registered manager agreed to progress this matter.

There were notice boards at the service which provided a range of information for people to access and be kept aware of their rights and choices. Including details of 'self-help' groups, fact sheets on safeguarding matters, mental health recovery, anxiety and depression, human rights, the complaints procedures and details of local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. There was a guide to Calder View, providing details of the services and accommodation available, additional information was publicised on the provider's internet website.

People had free movement within the service and could choose where to spend their time; however there were some expectations around respecting each other's privacy. All the bedrooms were single occupancy and people had keys to their rooms. We saw staff respecting people's private space by knocking on doors and waiting for a reply before entering. One person told us, "They always knock on the door." Staff described how they upheld people's privacy within their work, by prompting people sensitively prompting their personal care needs and maintaining confidentiality of information. Due to a lack of office space the registered manager often worked in the lounge, we noted action had been taken to reduce this intrusion on people's privacy. However, we observed a specific example whereby a person overheard a general discussion, which although not confidential provided a clear indication improvements were needed. We brought this matter to the attention of the area manager and we will monitor progress on our next inspection.

Good

Is the service responsive?

Our findings

We looked at how people received personalised care that was responsive to their needs. We discussed with people, managers and staff, examples of the progress people had made, resulting from the service being responsive and developing ways of working with them. People spoken with said, "I enjoy living here things are fine," "It's better here for me, I'm doing okay" and "Broadly speaking things are alright." An advocate spoken with explained the progress the person they represented had made since moving into the service.

People had individual care and support plans, which had been developed in response to their needs and preferences. All the people spoken with had an awareness of their support plans and said they were involved with reviews. One person commented, "I know what's in my care plan. I have regular reviews."

There was an electronic care planning system in place. Staff had the use of computers and used their own personal login details to access the information. The system was designed to enable the assessment and recording of people's identified needs and preferences, which were then linked with action plans providing directions to staff on meeting the needs. There were also paper copies of the care plans which were made accessible for people to refer to. The care plan process had been developed to include a 'recovery star' model, this is a nationally recognised tool which supports people to work collaboratively with staff to identify what is important to them and the goals they wish to achieve.

There was an emphasis in the care planning process on proactively responding to individuals, promoting their well-being and developing their skills. The 'recovery star' model encompasses 10 life domains, including: managing mental health, self-care, living skills, social networks, relationships, responsibilities, self- esteem and trust and hope. The care and support plans and other related records we reviewed, included people's needs and choices. The plans contained person centred details on how people's care and support was to be provided. The written structure of one care plan lacked clarity on the actions to be taken in response to the person's needs and included 'recovery star' text which was misleading. However, the team leader took action to pursue and rectify this matter during the inspection. There were additional individualised care plans in response to people's needs which did not fit within the 'recovery star' model. This was to ensure all their identified needs were responded to.

Records were kept of people's daily living activities, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours and specific health care needs. There were 'hand over' discussion meetings between staff to communicate and share relevant information. These processes were to enable staff to monitor and respond to any changes in a person's needs and well-being. Records and discussion showed processes were in place to review people's care and support. There were also records of reviews with the involvement of others, including care coordinators and community psychiatric nurses.

People indicated they were mostly satisfied with the individual and group activities they experienced at Calder View. They told us how they were supported to engage in activities within the local community and were encouraged to pursue their hobbies and interests. This included, trips to local towns, swimming,

shopping, football, attending places of worship, clubs, shopping and meals out. There was a 'directory of activities' for people to refer to. People were encouraged and supported to achieve daily living skills such as, involvement with their medicines, using public transport, doing laundry, cooking, baking and cleaning as part of their recovery, skill development and confidence building. There were 'weekly planners' to agree and arrange daily activities. The registered manager had also introduced 'activity agreements' to provide clarity around mutually agreed expectations and promote a positive experience when people accessed community. One person explained, "I sign agreements when I go out. It's fair so I agree things."

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The registered manager was aware of this standard and the provider was reviewing the way information was presented for people. We noted people's communication needs were reflected in their support plans. A new process had been introduced to highlight people's specific communication needs and preferences. Information in support plans, the guide to the service, satisfaction surveys and the complaints procedures had been reviewed and were presented in a 'user friendly' format.

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. People spoken with were aware of the complaints procedures. They made the following comments, "I would approach staff if I had a complaint," "At my last review my keyworker asked if I had any complaints" and "If I had a complaint I would talk to [the manager or team leader] I think they would sort it out." People also said they could raise concerns in residents meetings and there was a suggestion box in the hallway.

The complaints procedure was accessible to people who used the service. The information provided guidance on making a complaint and how it would be dealt with. There were 'user friendly' complaints forms were available for people to complete if wished. There were processes in place to record, investigate and respond to complaints and concerns. We noted there had not been any formal complaints with thin the last 12 months. Staff spoken with expressed an understanding of their role in supporting people to make complaints and described how they would respond should anyone raise concerns. The registered manager described the systems in place to monitor complaints, to identify and proactively respond to any patterns and trends.

Calder View did not usually provide end of life care. However the care plan process made provision for people's specific wishes and choices to be recorded and the manager described how the service would respond in meeting people's needs.

Good

Is the service well-led?

Our findings

The service promoted a clear vision and approach, to deliver support which achieved positive outcomes for people. People spoken with expressed an appreciation of how the service was run; they were aware of the management arrangements at the service. They told us, "The registered manager and team leader are alright, they are approachable," "The team leader is here most days" and "The manager and team leader are nice."

The service's vision and philosophy of care was reflected within written material including the guide to the service and policies and procedures. There were 'vision and value statements' on display, about empowering people and providing person centred support. New staff were made aware of the aims and objectives of the service during their induction training. They had been provided with job descriptions, which outlined their roles, responsibilities and duty of care. Staff spoken with were well informed and had a good working knowledge of their role and responsibilities. We found staff were enthusiastic about their work; one commented, "Everyone here is really supportive." They confirmed there were daily communication 'handover meetings' and regular staff meetings. We reviewed records of the most recent staff meetings and noted various work practice topics had been raised and discussed. One member of staff told us, "We can speak up and they listen to us. They give us positive praise for our work with people."

The registered manager and team leader had responsibilities for other services in the organisation, but spent regular time at Calder View. If the registered manager or team leader was not present, a member of staff with designated responsibilities was identified as a shift leader. There were daily 'shift planners' which were completed to highlight specific roles, duties and responsibilities of the team members on duty. There were on-call management arrangements. This meant a member of management was always available for support, direction and advice. The management team was supported and monitored by an area manager and there were regular meetings with managers from other services in the organisation.
The registered manager had attained recognised qualifications in health and social care. She had updated her skills and knowledge by completing the provider's mandatory training programme and through attending conferences and meetings. Throughout the inspection, the registered manager expressed commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection process.

Processes were in place to seek people's views on their experience of the care and support they received. They could express their opinions on a day to day basis, during their reviews and at residents' meetings. The service's suggestion box also gave people the ongoing opportunity to make comments and put forward ideas for improvements. People had been invited to complete an annual satisfaction survey. The results had been collated, analysed and shared with the staff team. We noted the majority of responses were positive and people indicated they were satisfied with the service. Action plans had been devised accordingly in response to the findings, commits and suggestion. A staff consultation survey had also been carried out and appropriately responded to. Information within the Provider Information Return (PIR) showed us the registered manager had identified several matters for development within the next 12 months.

There were systems in place to monitor the quality of the service. This included a system of daily, weekly and monthly checks. The area manager carried out monthly compliance visits and the findings were shared with the registered manager for action. Audits were in place to monitor areas such as, medicine management processes, care plans, staff training, health and safety and the control and prevention of infection. We noted there were examples where shortfalls had been identified, addressed and kept under review as part of an action plan. There were corporate incentives and development plans introduced by the provider, to progress the service in response to the findings of audit systems, consultation surveys and changes in the care sector.

The service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including: local authorities, the health authorities, and commissioners of service. The service had achieved the Investors In People (IIP) award in July 2016. IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in employee support and development. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. Our records showed that notifications had been appropriately submitted to the CQC.

We noted the service's CQC rating and the previous inspection report were on display at the service; the rating was also displayed on the provider's internet website. This was to inform people of the outcome of the last inspection.