

Balance (Support) CIC Woodbury

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

This inspection took place on 28 and 30 September 2016 and was unannounced.

Woodbury provides residential care for up to 14 people on a permanent basis and also has one bed available for respite care. It provides care for people who have learning disabilities and/or physical disabilities, including people with autism spectrum disorders, epilepsy and mental health needs. At the time of our inspection 14 people were using the service on a permanent basis and another person visited for respite care on the second day of our inspection.

There was a registered manager 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.

At our last comprehensive inspection in November 2015 we gave the service a 'requires improvement' rating. We followed up our concerns about insufficiently robust risk assessment, risk management and audit systems at a focused inspection in January 2016 and found they had all been addressed. We also found in November 2015 that the provider was breaching the regulation in regards to safe staffing, because there were not enough staff deployed on shifts to keep people safe. We did not follow this up in January 2016 because not enough time had passed for the service to demonstrate improvement in this area.

At this inspection, we found the provider had increased staffing levels and carried out an assessment of people's needs with regard to staffing levels. We saw there were enough staff to care for people safely.

People told us they enjoyed living at Woodbury. One person said it was "very good." Another person said, "I like it here. I have friends here." A third person told us, "I like it. It's a nice place and I have my own room." People felt safe using the service, were able to report concerns and staff knew how to recognise and report abuse. Managers followed appropriate procedures to follow up allegations of abuse. Robust procedures were in place to help ensure that unsuitable staff were not recruited to work with people.

There were systems in place to identify and manage risks to people's safety in proactive ways that did not unnecessarily restrict people's freedom. This covered both general risks posed by the environment and risks that were specific to individuals. Risk assessments were personalised and regularly updated. Staff had opportunities to discuss safety concerns and the registered manager used systems to collate information about accidents, incidents and concerns so they could identify any trends and monitor risks to people's safety.

Medicines were stored, handled and administered safely. Although the service had reported a number of medicines errors during the year before our visit, the provider had identified this and put measures in place to prevent errors from happening and to ensure that errors were quickly identified and dealt with appropriately.

Staff received the supervision, support and training they required to perform their roles effectively. This included special training in response to feedback from outside professionals about staff knowledge. The provider enlisted healthcare and other professionals to provide specialist training to ensure staff were up to date with current best practice in supporting people with their specific needs. Healthcare professionals told us staff were good at following professional advice and meeting people's healthcare needs. Staff supported people to access healthcare and other services when needed and people had personalised plans to help staff provide them with the care and support they needed and wanted for their health.

Staff obtained people's consent before carrying out care tasks. Care plans contained information to help staff do all that was reasonably possible to help people understand the information they needed to consent to their care. If people did not have the capacity to consent, the provider followed the processes that are legally required by the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) to ensure that decisions made about people's care, including any restrictions on their freedom, were made in their best interests and did not compromise their rights.

People received a variety of nutritious food and drinks that they enjoyed. Staff were aware of people's specific needs around nutrition, including cultural and religious needs and other dietary requirements, and took action to make sure these were met.

People and relatives fed back that staff were kind and caring. We saw staff interacting with people in a way that was respectful and friendly, although sometimes staff did not talk to people when supporting them to eat which meant they may not have been fully aware of what they were eating or what staff were doing. Staff knew people well and used appropriate methods of communication according to people's needs, although there was a lack of detailed information about people's life histories that would help staff understand people better. We recommend that the provider explore life history work with people and, if appropriate, families and others who know people well.

Staff offered people choices about their care, gave them the information they needed to make choices and kept them informed about what was happening. Staff showed respect for people's privacy, dignity and independence, although people's personal records were not always stored securely. Managers were in the process of taking action to address this concern.

People had assessments of their needs and these were used to complete personalised care plans. The care plans showed the support people needed to complete everyday tasks and activities, how they preferred to be supported and what was important to them. Care plans were designed to enable staff to support people in a person-centred way. Although some relatives and visiting professionals felt there could be more activities provided, the registered manager was in the process of making improvements to the activities timetable and a number of group and individual activities took place during our inspection. People received support to attend activities and religious services in the community, go on holidays and use the garden at home.

There were systems to ensure that the provider responded appropriately and promptly to concerns and complaints that people and visitors raised. We saw examples of these showing action was taken to resolve any problems and prevent them from happening again.

People, staff and relatives felt the registered manager led the service well. The manager had worked to make the culture of the service more supportive, person-centred and open. Staff told us they had opportunities to express their opinions and the manager listened to them. Roles and responsibilities of staff were clear and staff knew whom to approach for help and support. The manager was aware of challenges faced by the

service and told us how they addressed these, such as issues with poor record-keeping. We saw improvements had been made in this area. People, staff and relatives felt the service had improved over the last year and was still getting better. The provider used a range of audits and checks to assess, monitor and improve the quality of the service. Where these identified action to be taken, the registered manager ensured this was done.

There were links with the local community that helped people to feel involved, empowered and valued. The provider worked with other organisations to improve the quality of the service and promote best practice.

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.

There were systems to ensure that people were protected from abuse and discrimination. Staff knew how to recognise and report abuse.

Risk assessments and management plans were in place to protect people from harm.

There were enough staff to keep people safe and the provider followed safe recruitment procedures.

Medicines were stored, administered and recorded safely. There were systems to prevent and quickly identify medicines errors.

Is the service effective?

Good ●

The service was effective.

Staff received appropriate training, supervision and support, including specialist advice from healthcare practitioners. People received the healthcare support they needed.

Staff knew the importance of obtaining people's consent for people's care and followed the correct procedures to ensure decisions were made in people's best interests when they did not have the capacity to consent.

People were supported to have a varied and nutritious diet that met their needs and preferences.

Is the service caring?

Good ●

The service was caring.

Staff knew people well and demonstrated positive caring relationships with them. They spoke to people respectfully and demonstrated awareness of people's individual communication needs.

Staff gave people the information they needed to make choices

about their care. Staff respected people's privacy and promoted their independence, although people's personal records were not always stored securely. Managers were in the process of taking action to resolve this.	
Is the service responsive? The service was responsive. People had person-centred care plans that informed staff how to meet their needs, including their preferences and what was important to them. People received support to participate in activities both indoors and in the community. The provider responded appropriately to concerns and complaints that people or their relatives made.	Good 
Is the service well-led? The service was well-led. There was an open and supportive culture that was inclusive and challenged discrimination. There were opportunities for people, relatives and staff to express their opinions about the service and managers listened to them. There were strong links with the local community and the provider worked to involve and empower people more within their community. There was a range of audits and checks that the provider used to continuously assess, monitor and improve the quality of the service. We received feedback that the service had improved over the last year.	Good 

Woodbury

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 28 and 30 September 2016 and was unannounced. It was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports, feedback we received from people's relatives and notifications the provider is required to send to us about events that happen within the service.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who used the service, three relatives, four members of staff and two visiting health and social care professionals. We spoke with the registered manager and also the organisation's chief executive and head of operations. We looked at three people's care plans, three staff files and a number of records relevant to the management of the service such as audits and staff rotas.

Is the service safe?

Our findings

People and relatives told us the home was safe. One relative said, "I had safety concerns before but that was before the current [manager and staff team]. I have no concerns now."

At our last comprehensive inspection in November 2015 we found that the provider was breaching the regulations in regards to safe staffing because not enough staff were deployed on each shift to care for people safely.

At this inspection, the registered manager told us they had been able to address concerns previously raised about staffing levels. They told us they felt there were now enough staff to care for people safely although they would need more to provide a good quality service with increased levels of activities and to continue meeting people's needs as they changed due to ageing. To illustrate this, they had carried out an assessment of the staffing needs of the service according to how much staff time each person needed to carry out all the tasks in their care plan and at the time of our inspection this was under review by commissioners. The service had begun using an agency to supply extra staff cover in emergencies. Rotas showed that the proportion of staff to people was consistent and met the numbers assessed as being needed to care for people safely. We observed staff caring for people and saw that staff had enough time to sit and chat with people and staff immediately went to people when they needed help. We saw that where two members of staff were required to assist people with moving and handling processes there were enough staff to do so. This showed there were enough staff to keep people safe.

Information was displayed in an accessible format about how people could speak up about their concerns if they felt unsafe. Staff we spoke with were aware of how to recognise and report abuse or allegations of abuse. They used systems to monitor people for signs of abuse, such as documenting and monitoring any marks on people's bodies, and to keep people's personal money safe and prevent financial abuse. During the inspection, a person made an allegation of abuse to us and later repeated it to managers. When we reported this to the registered manager, they immediately began following their procedure for investigating the incident and reported it to the local safeguarding team. This helped to ensure people were protected from abuse because there were robust procedures in place to recognise, report and investigate it.

We discussed recent safeguarding reports with the registered manager, including an increased number of incidents of aggressive behaviour between people who used the service. We saw evidence that one person whose behaviour was challenging the service received continuing support from a behaviour specialist. There was a management plan in place for staff to reduce the risks posed by the behaviour without compromising the person's rights. This was reviewed regularly and during our inspection a meeting took place for the whole staff team and managers to discuss what interventions were working, what was less helpful and how to respond consistently as a team. Staff told us they took a proactive approach to promoting the person's quality of life to reduce the likelihood of them presenting with aggressive behaviour and their care plan set out how staff should do this. Staff wrote monthly reports for each person summarising any accidents, incidents and safety concerns so managers could analyse them and identify any trends.

People had personalised risk assessments and management plans to protect them from risks such as those associated with epileptic seizures, developing pressure ulcers, bathing and participating in specific activities that they were interested in. These contained detailed information about what the risks were and what staff should do to reduce them while supporting the person to remain as independent as possible. For example, staff were required to supervise one person in the bath due to the risk of them experiencing seizures, but did not directly assist them to wash because they were able to do this unaided. The management plans included information about how to involve people in managing risks, for example by talking to them about what was happening. We saw that people with reduced mobility used equipment such as pressure relieving cushions to protect them from the risk of developing pressure ulcers and those who used equipment to help them move around the home had risk assessments and detailed care plans in place to help ensure staff supported them to do so safely.

There were measures in place to help ensure the environment was safe. People were able to demonstrate where fire safety equipment was kept and knew what to do in the event of a fire because there were regular fire drills. Staff carried out daily checks to ensure hot water was at safe temperatures. There was a variety of equipment such as hoists and bath chairs to help people with physical disabilities use facilities safely. These were checked and serviced regularly in line with the manufacturers' instructions. Sharp knives were kept in a locked drawer, which meant that people could freely access the kitchen when they wanted without being exposed to the risk of injuring themselves on blades. This showed how staff worked to keep people safe while restricting their freedom as little as possible.

We saw evidence that the provider carried out appropriate checks on new staff, such as carrying out criminal record checks, obtaining proof of their identification and right to work in the UK and references. This helped to ensure that people received care and support from suitable staff.

We saw that medicines were stored, handled and recorded appropriately to help ensure people received them as prescribed. Senior staff checked administration records after each round of medicines to make sure people received their medicines and that staff had recorded them appropriately. Staff checked daily that medicines were stored at suitable temperatures and took the appropriate action if they were not. Monthly medicines audits took place and the provider had introduced new training for staff led by a pharmacist. There were measures in place to prevent staff making errors when administering people's medicines, which previous audits had identified as being a problem. Staff confirmed that only senior members of staff were allowed to administer medicines, shift leaders checked the medicines administered during the previous shift and if staff made an error they were not allowed to administer medicines again until they had carried out refresher training and passed a competency assessment. Records showed that staff took appropriate action when errors had occurred such as immediately obtaining medical advice. This ensured that any errors were quickly identified and dealt with appropriately.

Is the service effective?

Our findings

People were protected from the risks of poor care because staff received training, supervision and support to enable them to fulfil their roles appropriately. We discussed with the registered manager some information of concern we had received before the inspection about staff training in relation to moving and handling and managing the risk of people choking. They told us what action they had taken, including extra training sessions with relevant professionals and assigning a moving and handling lead role within the staff team. Staff training records confirmed this. We saw a written compliment the service later received from a speech and language therapist, praising staff for their knowledge about choking risks and how to respond. The registered manager told us that a local healthcare provider supplied training to staff that was tailored to meet the needs of people currently using the service. Staff also received regular supervision to support them in their roles and there were opportunities for professional development. For example, managers told us about a member of staff who was employed as a domestic but had shown willingness and potential to develop in their role and by the time of our inspection they were a senior member of care staff. Staff confirmed that they received enough good quality training and support to enable them to meet people's needs effectively.

Staff told us they also received a lot of support to help them stay up to date with current best practice. For example, a learning disability nurse visited the home to train staff about preventing, identifying and treating urinary tract infections. We saw evidence that the registered manager actively sought advice about best practice, for example by attending multidisciplinary meetings about specific aspects of care such as managing behaviour that challenged the service. We saw examples of work staff had done that followed recommendations set by healthcare providers and other specialists.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). 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. We saw evidence that people had assessments of their mental capacity to make each significant decision about their care. Where people did not have capacity, 'best interests' meetings took place involving families, doctors and other professionals involved in people's care to make decisions. Staff were aware of the principles of consent. They knew they should obtain people's consent where possible before carrying out any care tasks with them and where people did not have capacity to do this, staff referred to their care plans, told people what was happening and monitored them for signs of discomfort.

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, 12 of the 14 people using the service were assessed as needing to be deprived of their liberty to remain safe. People had the appropriate paperwork in place showing that

DoLS had been applied. However, DoLS paperwork had expired for two of the three people whose files we looked at, meaning that the restrictions applied to their freedom were no longer within the required legal framework. We discussed this with the registered manager, who showed us evidence that they had applied for renewal of the DoLS authorisations and were waiting for the relevant authorities to carry out further assessments.

People told us they liked the food prepared at the home. One person said, "I liked the chicken." We looked at the planned menu for four weeks, which showed a wide variety of balanced meals. Some people were at risk of choking on food or drinks and we observed staff following guidelines from speech and language therapists to support people to eat and drink whilst reducing the risk of them choking. We saw some people receiving drinks containing thickening agents and food that had been mashed or cut into small pieces. Staff assisted some people to eat and observed others depending on their abilities to make sure they ate and drank enough. One person told staff they had had a "very good lunch." We observed staff regularly offering people a choice of drinks throughout the day to ensure they remained hydrated.

There was information in the kitchen about people's nutritional needs and how to meet them so that this was readily available to kitchen staff. This included information about people's allergies, different food textures that some people required to manage their risk of choking on food and cultural or religious needs. Staff were aware that one person did not eat certain food items for religious reasons and they had a dedicated storage area for food that met their religious and cultural needs. Records showed this person regularly received food from their culture of origin. There was also information about support people needed to maintain a balanced diet. For example, one person's care plan stated that they were unlikely to eat nutritious food unless encouraged to do so. Staff we spoke with were familiar with people's nutritional needs and therefore were enabled to support people to maintain their health through a varied and nutritious diet.

Relatives told us the service had improved the support people received to meet their healthcare needs. Staff told us the service had a good relationship with a local healthcare provider and that they were able to access professionals such as speech and language therapists, physiotherapy and nursing services easily when people needed them. We spoke with a healthcare professional working for this service and they fed back positively about staff, saying they were "very conscientious" and always acted promptly on advice they received from healthcare professionals.

Records showed that staff recorded signs and symptoms of ill health for each person and monitored them or took action where appropriate. There was evidence that people received regular input from healthcare providers, including support to manage long-term health conditions. Each person had a Health Action Plan, which is a personalised document designed to support people with learning disabilities to make choices about their health and to receive the healthcare they need. People's healthcare needs were monitored and reviewed regularly to ensure they continued to receive the support they needed to maintain good health.

Is the service caring?

Our findings

People said staff were "kind" and "very nice" and a relative told us staff were "great, always laughing and well suited to the job." A visiting healthcare professional told us staff were caring. They told us, "They speak to people appropriately. They interact well and have a laugh with people and always explain what's happening."

Another relative commented on the good relationship their family member had with the staff. We saw staff interacting with people in a caring way, using different communication styles that were appropriate for people's needs and abilities. For example, we saw staff using Makaton, a signing system developed to help people with learning disabilities understand verbal information. Staff spent time chatting with people and when one person spontaneously started singing, staff joined in and turned it into a group activity, encouraging other people to take part. Staff used humour to make care tasks more enjoyable for people and we saw people responding by smiling and joking back. This helped to create a homely, friendly atmosphere in the home and demonstrated that staff took the time to establish rapport with people and knew them well.

We observed staff and managers discussing people's care needs in a respectful and person-centred way at a meeting. For example, the registered manager reminded staff that people's time was valuable and they should not waste it by failing to communicate plans with them in a timely manner.

There was information in people's care plans to help staff get to know them. This included information about their communication styles, sense of humour and when they might need support or reassurance. However, we did not see detailed information about people's life histories, although they did record some basic facts. A thorough knowledge of people's histories can help staff develop a better understanding of the contexts behind some aspects of people's behaviour and strengthen positive caring relationships with people.

We recommend that the provider explore life history work with people and, if appropriate, families and others who know people well.

One person told us they were able to make choices, saying "I choose my clothes" as an example. Another person's relative told us, "[My relative] is talking more and making more decisions for himself. He is more outspoken about what he wants." They said this was because of the improved support their relative received from staff to boost their confidence. Minutes from meetings showed staff discussed how to support people better to make their own choices, such as holding food tasting sessions to see what people liked before planning menus. We observed staff offering people choices and giving them information such as telling a person they were going to push their wheelchair to the dining room before doing so. However, we also observed that when staff were assisting people who had visual impairments to eat they did not always talk to them about what they were doing or tell them what the food was, which meant those people may not have known what they were eating or what was happening. We discussed this with managers, who said they would speak with staff about it and told us they had some sensory awareness training due to take place.

soon to improve staff understanding of people's needs.

Some information was displayed in an accessible format to help people understand it. There was a pictorial menu board in the dining area showing what choices were available for that day's meals. We saw people pointing at the board and talking about what they wanted. We also observed a member of staff supporting one person to plan the following week's menu using a range of food pictures. Another person told staff where they wanted to go that day and staff arranged for the person to go there. This showed how staff enabled people to make choices about their care.

People told us staff respected their privacy and staff gave examples of how they ensured people had privacy for personal care tasks. One person said, "I have a lock on my door." However, we observed that people's personal records, such as care plans, were not always stored securely. Because these were left on shelves in an unlocked room unauthorised persons could access them and people's privacy might be compromised. We discussed this with managers, who told us they planned to move records to a suitably secure location and in the meantime they asked staff to lock the door when the room was not in use.

Staff told us they took a "support rather than care for" approach to promote people's independence and give them more choice in how they lived their lives. People's care plans included information about how staff could help them remain as independent as possible such as details of what tasks they could perform with and without prompting. We saw a timer in a bathroom, which staff told us was there so that one person could bathe independently because it provided the prompt they needed to get out of the bath. A relative told us the home had supplied their family member with a 'big button' controller that made it possible for them to change the TV channel independently. This helped people to maintain a good quality of life because they were enabled to have more control over how and when they did things.

Is the service responsive?

Our findings

Each person had an assessment of their needs and these were used to create a personalised care plan. This included information about people's likes and dislikes, hobbies and interests and what they enjoyed doing. Each person had a brief summary of their care needs to help staff and others working with people to familiarise themselves with people's needs. There was also more detailed information about the support people needed and how they preferred staff to provide it. This included detailed, person-centred information about how people expressed themselves if they did not communicate verbally, what was important to them, what situations they found difficult to cope with and how staff could support them to avoid those things or make them easier for the person to manage. There was information about how people preferred to spend their time, including how to ensure their social needs were met. Staff discussed people's care plans at team meetings to ensure all were aware of people's support needs. Instructions and guidance from other professionals was incorporated into care plans and they were reviewed regularly to ensure they remained up to date with people's changing needs. People and their relatives were involved in care plan reviews, one of which took place during our inspection.

We saw evidence that where people were able, staff had explored with them their preferences about how they wanted their care to be delivered and then recorded it in their care plans. For example, staff had asked people about whether they preferred to be supported by male or female staff for personal care. This helped staff to provide people with personalised care that met their needs and preferences.

Staff told us being involved in preparing meals was important to one person. We later observed this person asking staff about cooking the evening meal and staff told them they could participate. People had individual activities timetables, which were in line with the interests, preferences and abilities recorded in their care plans. We saw people taking part in the activities as planned, although one person's timetable indicated they visited a theme park one day a week but this did not happen weekly. Staff told us they were in the process of reviewing this person's activities timetable so the person had the correct information about what was happening.

A visiting professional and a relative told us they did not feel there were enough indoor activities to meet people's needs at the home, particularly for those with more complex needs. We saw evidence that there were plans in place to improve the provision of activities, however. The registered manager told us the deputy manager was visiting a community facility the day after our inspection to look at what activities might be suitable for people using the service. During our inspection, we observed people going out to take part in a variety of activities outside the home, such as visiting a day centre, going to a local city farm and taking part in a Zumba class. One person told us about a holiday they had recently been on and showed us photographs of various activities they had done there with staff. Another person told us they enjoyed going shopping regularly with staff. Records showed that staff supported people with activities on most days, including sensory activities like swimming and massage sessions for people with sensory impairments.

The home had a large, well maintained garden with seating and a swing that could be used with wheelchairs. Staff and relatives told us the service had recently held a garden party and this had been a

great success. During our inspection, a music activity took place and several people participated. We also saw staff engaging people in individual activities such as chatting over a hot drink and going for walks. This helped to stimulate people and encouraged them to keep active.

We saw evidence that a vicar had visited people at the home. They left a written compliment to say how pleased they were that staff were supporting many people to go to church regularly. We saw how staff worked to meet people's cultural and religious needs in other ways, such as supporting one person regularly to buy food items to meet their cultural needs. We saw evidence that staff supported people to stay in touch with their families and others who were close to them. Relatives told us they would appreciate more individual feedback about what their family members did during the week but said that in general staff were good at keeping in touch with them.

We saw evidence that the provider dealt with concerns and complaints appropriately. They recorded the action they had taken in response, fed back about this to the person who complained and, if necessary, put new systems in place to ensure the problem did not occur again. For example, a relative had raised a concern about people's wheelchairs being dirty. We saw evidence that cleaning wheelchairs was now included as a permanent item on night shift plans and night staff recorded that they did this on each shift. Wheelchairs we saw during our inspection were free of visible dirt. We also saw an accessible complaints form with pictures and symbols was available for people to use. This helped ensure that people were enabled to raise any concerns they had.

Is the service well-led?

Our findings

People, relatives and staff told us the home was well-led and they liked the manager. One relative said, "The manager is friendly. It's a very happy home." The registered manager and chief executive told us how they had worked to promote a positive culture within the service, for example by taking a supportive, 'blame free' approach to tackling safeguarding concerns and medicines errors with staff and by involving people, relatives and staff more in decisions and plans about the service. We saw documentation showing how the registered manager used staff meetings to challenge discriminatory or unprofessional attitudes within the service and to encourage staff to do the same. Staff told us they had opportunities to have their say and make suggestions about how to improve the service. They were able to feed back any concerns to the manager on a daily basis as part of the handover process. The registered manager told us the staff meeting that took place during our inspection was happening because staff had fed back that they did not always have opportunities to discuss with colleagues how to manage specific issues around behaviour that challenged the service and felt they needed to do so. We saw minutes from a meeting for people who used the service displayed in a communal area so that people could refer to these and see what was discussed.

The service had strong links with the local community. For example, neighbours were invited to the garden party held at the home and had the opportunity to learn about the service and meet the people who used it. We heard about plans for the service to send a representative to a neighbourhood community meeting. Some people were involved in volunteer work at the nearby farm. There were plans to strengthen links with a local school that had previously been involved in some gardening work at the service. The provider operated some community-based projects such as cafes run by people who used services and people who used this service visited them regularly. The provider had also previously involved people with learning disabilities in staff recruitment processes and planned to reintroduce this. At the time of our inspection the home employed one member of staff who had a learning disability. The community links and involvement of people with learning disabilities helped to promote a positive and empowering culture for people who used the service.

The registered manager told us about the challenges they faced, such as changes of management and subsequent high staff turnover leading to an unsettled staff team. They told us how they had managed these challenges, including discussions with the staff team about consistency in their approach and maintaining good communications. They had found improving record keeping a challenge and had introduced some new daily report forms to help ensure staff recorded the right information about care they provided to people. We looked at these and found that records were generally of an acceptable standard although there were occasional gaps where information was missing or unclear, such as what a person had eaten for their main meal or what activities they took part in. The registered manager told us they were continuing to work on improving record keeping and we observed that a discussion about this took place at the staff meeting during our inspection. Records showed this was also discussed at previous team meetings.

There was a clear leadership structure with the registered manager, deputy manager, team leader and senior staff. The registered manager had assigned 'champion' roles and responsibilities to specific staff for areas such as managing behaviour that challenged the service, medicines management and activities. This

provided a structure so staff knew whom to approach if they needed specific help or support. Staff fed back positively about these roles, saying it had helped improve the quality of the service and that everyone felt involved. We saw evidence that senior staff allocated tasks for each shift to ensure responsibilities were shared and all essential tasks were completed.

We observed senior managers giving positive feedback to staff about the work they were doing. Managers involved staff in discussions about how to improve care the service provided to people, including asking about what they did well and how they did it so the staff team could all learn from it.

A relative told us the quality of the service was "much improved" over the last year and said they had seen people making clear progress towards their goals in this time. Staff we spoke with also felt the quality of the service had improved. There was a number of systems in place for the provider to assess, monitor and improve the quality of the service, including use of a social care consultant to help design and implement improvements to the service, and managers attended events such as seminars on what outstanding care looks like. The provider had carried out a survey the month before our visit asking people's relatives for feedback about the recent garden party and the quality of care in general. The feedback was positive, although relatives gave suggestions for further improvement, which the registered manager told us they were working on. We saw an audit that the chief executive carried out quarterly and this had identified where the service fell short of quality targets, set actions to address these areas and recorded when they were complete. A monthly environmental safety audit for the three months before our visit showed where areas for improvement were identified and action taken to address these. This helped the provider to continuously monitor and improve the quality of the service.

The registered manager told us they had informal conversations with people's relatives about what they thought worked well and what could be improved. Staff and managers all told us about ideas they had to improve the service and we saw the registered manager's improvement plan for the service. We noted that there were no target or actual completion dates on the plan, which would have made it easier for the manager to check their progress and make sure tasks were not forgotten. However, during the course of our inspection we saw evidence that several of the actions identified on the plan were complete.

The registered manager told us how they had worked to build and strengthen links with other providers, such as a local multidisciplinary healthcare provider accessed by people using the service. The service was a member of a regional organisation that provides support for social care providers to keep up to date with best practice and improve the quality of their service. This organisation had recently carried out a 'mock inspection' of the service to help the provider assess the service's strengths and areas for improvement. The registered manager had incorporated the findings into their action plan and we saw that some of the actions were completed.