Leonard Cheshire Disability

White Windows - Care Home with Nursing Physical Disabilities

Inspection report

Fore Lane
Sowerby Bridge
Halifax
West Yorkshire
HX6 1BH

Tel: 01422831981
Website: www.leonardcheshire.org

Date of inspection visit:
09 August 2016

Date of publication:
15 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 9 August 2016.

We last inspected White Windows in November 2013. At that inspection we found the service was meeting all of the legal requirements in force at the time.

White Windows Care Home with Nursing and Physical Disabilities is a care home that provides accommodation and personal care for up to 25 people. Nursing care is provided.

A registered manager was in place. 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.

Staff said the management team were supportive and approachable. The new registered manager monitored the quality of the service provided and was introducing improvements to ensure that people received safe care that met their needs. People and their relatives had the opportunity to give their views about the service. A complaints procedure was available.

Not all areas of the home were well maintained for the comfort of people who used the service. We have made a recommendation about the maintenance of the environment.

People said they were safe and staff were kind and approachable. People were protected as staff knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. Staff had not all received updated training to ensure they had a good understanding and knowledge of safe working practices and people's care and support needs.

White Windows was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had some understanding of the Mental Capacity Act (MCA) 2005 and Best Interest Decision Making when people were unable to make decisions themselves.

People had food and drink to meet their needs. People had access to health care professionals to make sure they received appropriate care and treatment. Risk assessments were in place and they identified current risks to the person. People received their medicines in a safe way.

Systems were being put in place to ensure people received individual care that met their needs in the way they wanted. Staff knew the people they were supporting well and care was provided with patience and kindness. People's privacy and dignity were respected.

People had some opportunities for activities and outings but people we spoke with and relatives said more activities and stimulation needed to be provided for people. We have made a recommendation about increasing the activities provision.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People told us they felt safe. Staffing levels were sufficient to ensure people were looked after in a safe way. Staff were appropriately recruited.

Records accurately reflected risks to people's safety. Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not up to date to support staff to carry out their role effectively. Staff received supervision and an appraisal system was in place.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Some areas of the home needed to be better maintained.

Is the service caring?

Good

The service was caring.

We observed and people could tell us the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were helped to make choices and to be involved in daily decision making.

There was a system for people to use if they wanted the support of an advocate.

Is the service responsive?

Good

The service was not always responsive.

Records reflected the care and support provided by staff.

There were limited activities and entertainment available for people. We have made a recommendation about activities provision.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

The registered manager was introducing changes to make care more person centred and to include staff and people in the running of the service.

The home had a quality assurance programme to check on the quality of care provided.

White Windows - Care Home with Nursing Physical Disabilities

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 9 August 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with seven people who lived at White Windows, three relatives, the acting care supervisor, the area manager, six support workers, one nurse, one housekeeper, one cook, the maintenance person, one volunteer and a local authority representative who was visiting at the time of

inspection. After the inspection we spoke with the registered manager. We observed care and support in communal areas and looked in the kitchen, dining rooms, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for five staff, three people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager had completed.

Good

Is the service safe?

Our findings

People told us they felt safe and they could speak to staff. Peoples' comments included, "I like living here," "I do feel safe here," "It's perfectly safe here, I feel safe," "Sometimes staff don't have time to listen to me," and, "Sometimes there aren't enough staff so you can't go out." "A relative told us, "It's the best place for [Name] to be."

There were 25 people living at the service. The acting care supervisor told us staffing levels were determined by the number of people using the service and their needs. We were told there were six support staff and a nurse on duty during the day and five support staff and a nurse were available in the afternoon until evening. Our observations however and staffing rosters showed staffing levels were not consistently maintained each day to ensure there were enough staff to meet people's needs. Staffing rosters showed on some days there were only five support staff on duty during the day and four support staff on duty in the afternoon. We observed staff were particularly busy because of the needs of the people.

Staff told us 20 people required two members of staff to help with their moving and assisting support needs and 19 people required total assistance with their care and support needs. This meant when staff were busy attending to people other people had to wait for assistance. The area manager told us there some staff were on long term sick leave and there were six staff vacancies, rosters showed bank staff were sometimes used to make up the staffing levels. We were informed by the registered manager after the inspection that this had been addressed. We were told an additional two nurses, two support workers, a domestic person and full time maintenance person had been employed. Staffing rosters showed staffing levels were now consistently maintained with one nurse and six support workers during the day and one nurse and five support workers in the afternoon to ensure people received person centred care.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. Staff members' comments included, "If I had any concerns I'd tell the senior on duty," "I've done Calderdale local authority safeguarding training," and, "I'd tell the registered manager about it."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place. Eight safeguarding incidents had been raised since the last inspection three years ago. Safeguarding alerts had been raised by the service with the relevant local authority and investigated and resolved where necessary to ensure people were protected. The area manager told us learning and follow up action took place from any investigations to improve systems to ensure people were kept safe. For example, a recent safeguarding about medicines management had resulted in improvements to the system.

We checked the management of medicines. People received their medicines in a safe way. All medicines

were appropriately stored and secured. Medicines which required cool storage were kept in a fridge within the locked treatment room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Medicines records were accurate and supported the safe administration of medicines. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. The area manager told us any reported medicine errors were reviewed and action was taken to strengthen systems and help protect people with regard to medicines management.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the management team so that appropriate action could be taken. We were told all incidents were audited in the home and at head office to check action was taken as required to help protect people. The area manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. These included environmental risks and any risks due to the health and support needs of the person such as moving and assisting, epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. Our discussions with staff confirmed that guidance had been followed.

A personal emergency evacuation plan (PEEP) giving guidance if the home needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed monthly to ensure they were up to date.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of other checks were available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires Improvement

Is the service effective?

Our findings

Staff were positive about the opportunities for training to understand people's care and support needs. Staff comments included, "I've a National Vocational Qualification (NVQ), (now known as the Diploma in health and social care) at level 3," and, "We do some training on the computer."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work.

We had concerns staff had not received training to carry out their role safely and effectively.

The staff training records showed and staff told us they had received some training to meet peoples' needs and training in safe working practices. Staff responsible for administering medicines were receiving updated medicines training and senior support staff, who were to administer medicines for people with non-nursing needs had received the training. We were told there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. This training included, catheterisation, tissue viability and bowel management. However, the staff training matrix showed some of the staff training in safe working practices were out of date. For example, fire training, food hygiene and safeguarding. All staff had not received training about the requirements of the Mental Capacity Act. The staff training key performance indicator showed staff training at only 53% completed for the staff team rather than 100%. The registered manager told us because of staffing vacancies, staff had not had time to complete updated training. This meant staff had not all received the necessary updated training in safe working practices to ensure they delivered people's care and support needs safely and effectively.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was large, bright and spacious. We were told there was an on-going programme of refurbishment. A new bathroom had been created that contained a 'Jacuzzi' bath for people to relax. Most areas of the home were well-maintained for the comfort of people who lived there. However, during the inspection we found that some areas were showing signs of wear and tear. Some floor coverings in bedrooms, corridors and communal areas were marked and the parquet flooring in the dining room by the servery required some attention as the seal had lifted and some of the parquet tiles were loose. Paintwork was scuffed and chipped on skirting boards, walls and doorways in some areas including corridors and bedrooms. The middle floor landing was also furnished as a seating area with an atrium. However it was difficult for people to use as it was a storage area that contained equipment, boxes, trollies and wheel chairs. The area manager told us this inappropriate storage of items would be addressed with staff. The registered manager told us that financial expenditure had already been agreed to replace floor coverings and repair the parquet floor and to increase the hours available for the maintenance man to carry out regular improvements to the home as needed. Following our inspection, the provider confirmed that a full action plan had been put in place to address all the areas found to be in need of attention during the

inspection.

We recommend that the provider ensures a full programme of maintenance is completed to address areas of wear and tear within the home.

Staff told us and their training files showed they received supervision to discuss their work performance and training needs. Staff members' comments included, "A senior does my supervision," "I get supervision," "We have supervision every two-three months," and, "The manager does my supervision." Staff told us they were well supported to carry out their caring role. They said they could approach the registered manager at any time to discuss any issues.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Staff had an understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes.

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). The care supervisor and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us after the inspection two applications had been authorised and six applications were being processed.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. Information from the provider's quality improvement team for July 2016 showed that reflective practice had taken place with staff to ensure handover information was more robust and effective. The written handover record was more detailed and provided information about all people's current health and well-being when different staff came on duty to care for people. The daily care entries in people's individual records also provided information to staff to ensure all people's needs were met. Staff comments included, "Communication does work well," "Nurses handover to senior support workers who pass on the information to support workers," "Nurses do the main handover and senior staff attend," "We are told about any changes and if a person has been unwell," and, "Communication is quite good."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. The service employed a physiotherapist who attended the service one day a week. Staff received advice and guidance when needed from specialists such as the occupational therapist, dietician, psychiatrist and General Practitioners (GP). Records were kept of visits and any changes and advice was reflected in people's care plans. Written guidance was available for staff with regard to people's support requirements. For example, one care plan stated, "I manage to book my own GP appointments and go to see the GP when I'm not feeling well."

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. We saw food was well presented and looked appetising. People were offered a choice and a menu advertised what was available each day. People were positive about the food saying they had enough to eat and received good food. Their comments included, "There's plenty to eat and drink," "The food's alright," and, "The food is good." People had access to a servery in the dining room where they helped themselves to snacks and hot and cold drinks throughout the day.

We spoke with the cook who was aware of people's different nutritional needs and told us special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet which included milkshakes, butter, cream and full fat milk as part of their diet. The cook told us they received information from nursing staff when people required a specialised diet such as diabetic, soft or pureed food. We saw written information was available in the kitchen, for when the regular cook was not available, to show people's nutritional needs and captured any changes that had been communicated about people's dietary requirements.

People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. They gave guidance about the support people may need. For example, one person's care plan stated, "I need to be encouraged to drink water every two hours to stop me being dehydrated." Risk assessments were in place to identify if a person was at risk when they were eating or had specialist dietary requirements. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool.

Good

Is the service caring?

Our findings

We saw people appeared comfortable and relaxed with staff. During the inspection there was a calm and pleasant atmosphere in the home. Staff interacted well with people. Peoples' comments included, "Staff are very kind and caring," "Staff listen to me," and, "I like living here."

Staff engaged with people in a calm and quiet way. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff bent down as they talked to people so they were at eye level. We observed the lunch time meal being served in the dining room. The meal time was relaxed and unhurried. Tables were set for three or four and staff remained in the dining area to provide encouragement and support to people. Staff interacted with people as they served them. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle manner. For example, "How are you getting on," "Would you like some chocolate cake," and, "Have you had enough to eat?" We saw staff members who assisted people to eat explained what they were doing and reassured them as they supported them and provided words of encouragement. Staff asked the person's permission before they carried out any intervention

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. Support plans advised when people may want some privacy. We saw staff knocked on a person's door and waited for permission before they went into their room. Support plans included information about how people's personal care was to be delivered that respected their dignity. For example, "[Name] prefers two female carers." The area manager told us they looked at ways to ensure the person's dignity was always respected. For example, rather than providing intrusive observation for a person who was at risk of leaving the building they had looked at other ways to keep the person safe.

People told us they were offered choices and involved in daily decision making about aspects of their care. For example, activities, bathing and rising and retiring routine. Their comments included, "I just buzz for staff when I want to go to bed," "I get tired so I go to bed early," and, "I can have a bath when I want."

A detailed information pack was available for people when they started to use the service that detailed the facilities available and what people could expect when they came to live at White Windows. It was comprehensive and respected people's rights to live an ordinary life with few restrictions and 'unquestioning

recognition of their full human rights.' It advertised the organisation's disability charter and the values of the Leonard Chesire Organisation. These values included, valuing the 'uniqueness of each individual, integrity, excellence, pioneering and drive' within the organisation.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt cardio pulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

The acting care supervisor told us people who did not have relatives to provide advice and support to them would be supported by an advocate. Advocates can represent the views for people who are not able to express their wishes. An advocate would become involved where a person needed to have additional support whilst making decisions about their care.

Good

Is the service responsive?

Our findings

Some people commented there were limited activities and entertainment available within the home. People's comments included, "I love to listen to the radio," "I'd like more activities," "I run the tuck shop," "I like going shopping," and, "I go out for a pub lunch." A relative commented, "More activities are needed during the day, as people get tired at night."

The service used volunteers to assist with some aspects of service provision such as activities and driving the minibus for outings and appointments for people. A monthly programme of activities was available for people that advertised in house activities that took place in the service. However, we saw limited activities were available in July and August 2016. A weekly church service was advertised, fun exercise took place one day a week and a volunteer was available one day a week. At the time of our inspection when the volunteer was not available we did not see staff provide activities for people during the day if they wished to become involved. From our observations we considered improvements were needed to ensure that all staff interacted with people at other times, and not only when they carried out care and support with the person. The registered manager told us each person had one day a month to choose an activity and to go out shopping, for lunch or to follow their hobbies and interests on a one to one basis.

People told us they attended some local day resources within the community full and part time. The service also had three minibuses and people had the opportunity to go on outings as a group and individually. For example, to the farm, for a community lunch, to choir and to the cinema. A tuck shop was available on the premises that was very popular and was run by one of the people who used the service. People also had access to a library, computers and the internet.

We were told meetings were held with people who used the service. The acting care supervisor said people were consulted and asked for ideas. For example, menu suggestions and fund raising ideas. They also provided feedback from people about the running of the home. One person commented, "The cook comes over to get our opinions about the food." We saw meeting minutes for a meeting in March 2016 but more recent meeting minutes were not available. We were told meetings with people who used the service took place three monthly. After the inspection we were sent some meeting minutes for September 2016.

We recommend that regular consultation takes place with people including consultation about activities for people to take part in if they wish individually or in a group.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Assessments included risks specific to the person such as for falls, tissue viability, choking and nutrition. Risk assessments were regularly reviewed and evaluated in order to ensure they remained relevant and reduced risk.

Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, self-medication, mobility and falls

and personal hygiene. Evaluations were detailed and included information about peoples' progress and well-being.

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, one care plan for nutrition stated, "I like eating cereal and fruit juice for my breakfast and toast with a cup of tea." A one page profile was available in peoples' bedrooms, so new and agency staff had a precis of information about people's preferred routine and people of importance to the person. Care plans provided information for staff about how people liked to be supported. For example, two care plans for personal hygiene stated, "I can manage some tasks like brushing my teeth, brushing my hair and washing my face, provided staff have placed washing things within my reach," and, "I manage all my personal care." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. We saw that staff completed a daily accountability sheet for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Records showed and people told us they were involved in the review of their care and support needs. For example, one person's health care plan stated, "I have been involved in the development of my health plan. I have read it to see if I am happy with the content."

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Some people had visitors and some people went to spend time at their family home for a day or overnight stay. One visitor we spoke with was collecting their relative to take them on holiday with their family.

People's care records contained information which had been collected from the person or from their families about their life history and likes and dislikes. This gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. Information was available with regard to people's wishes for care when they were physically ill and recorded their spiritual wishes or funeral requirements.

People who used the service and relatives told us the registered manager was approachable and they knew they could approach them at any time to discuss any issues. People said they knew how to complain. One person commented, "I'd tell the manager. Relatives' comments included, "We've no problems at all," and, "I'd call in the office if I needed to." A complaints log was available and we saw eight complaints had been received since the last inspection three years ago that had been investigated and resolved. Resident meeting minutes also showed the complaint's procedure was discussed with people to remind them of how to complain.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place who had become registered with the Care Quality Commission (CQC) in 2014. They had taken over the management of White Windows in May 2016. They had been pro-active in keeping us informed and submitted statutory notifications to the CQC. These included safeguarding notifications, applications for DoLS and serious injuries.

The area manager told us the registered manager had introduced changes to the service to help its smooth running and to help ensure it was well-led for the benefit of people. The registered manager had started employment at White Windows in May 2016. Meeting minutes showed changes had been introduced and were in the process of being introduced to ensure the service was run for the benefit of people who used the service and that individual care was provided to people. For example, systems had been introduced to ensure communication was more effective and staff development opportunities were being created amongst support staff.

Staff meeting minutes showed the registered manager was introducing a more person centred approach to care provision within the service. We were told a new care planning system had been introduced to help ensure people received individual care and support in the way they wanted and needed. A one page profile was available for each person that gave more information about people's likes and dislikes so staff could deliver a safe, personalised service.

We were told the registered manager responded quickly to address any concerns. Staff and relatives spoke positively about the registered manager and the organisation. They said they felt well-supported. Staff comments included, "Brilliant manager in place," "I feel listened to," "The manager is approachable," "The manager is nice," "It's a lovely place to work," and, "The new manager has good ideas." A relative commented, "I need to get to know the new manager."

Staff told us and we saw staff meeting minutes to show staff meetings took place regularly and these included nurses and senior support and general staff meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Minutes showed staff had discussed service issues, health and safety, training, complaints, safeguarding alerts and the needs of people who used the service. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of monthly, quarterly and annual checks. They included health and safety, infection control, training, care provision, medicines and information governance. Audits identified actions that needed to be taken. The annual audit was carried out to monitor the safety and quality of the service provided. Records showed regular audits were carried out by a representative from head office and the registered manager to check on the quality of service provision. The area manager told us they carried out six weekly visits to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. Audits were carried out to ensure the care and safety of people who used the service and to check appropriate action

was taken as required. However these audits had not identified some of the issues we found during our inspection and although some of these issues were rectified as a result of our visit and others were subsequently included in action plans for the future, these had not been independently identified through the audit system prior to this.

Regular analysis of incidents and accidents took place. The area manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. The registered manager told us if an incident occurred it was discussed at a staff meeting to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out to staff, family members and professionals who supported people who used the service. We saw the aggregated survey results for 2014 for the Leonard Cheshire organisation. An individual service report was then produced for each location. Survey results showed they were predominantly positive. We were told questionnaires had been sent out in June 2016 and the results had not yet been analysed by head office.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staff training was up to date for staff to provide safe and person centred care to people. Regulation 18 (2)