Leonard Cheshire Disability

Agate House - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on the 19 and 21 April 2016 and was unannounced. When we last inspected the service in May 2013 we found that the provider was meeting the legal requirements in the areas that we looked at.

Agate House is a residential home in Ampthill providing nursing care and support to up to 36 people with physical disabilities. At the time of our inspection there were 35 people using the service.

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.

People were safeguarded from avoidable risk of harm and staff understood the process to follow to report concerns regarding people's safety. There were risk assessments in place which detailed how people could be supported safely. Staff received training in moving and handling which allowed them to move people safely using the correct equipment. People's care plans were person-centred and included information regarding their backgrounds, preferences and how they could be supported effectively. These were subject to regular review with involvement from people and their relatives where possible.

People's healthcare needs were identified and met by the service and a dedicated team of nurses with a variety of specialisms. External healthcare support was sought if required from community-based professionals. People had enough to eat and drink and the food and drink on offer took into account their individual needs and choices. There was a creative and vibrant programme of activities on offer so people could pursue their interests in and out of the home. People were treated with dignity and respect and had opportunities to have their opinions and views heard. People gave their consent to receiving care and treatment at the service.

Staff were not always supported through a regular programme of supervision and appraisal. The service did not supervise staff on a regular basis and some staff had been without a formal supervision for an extended period of time. The service had not acted upon their feedback to resolve this issue efficiently.

Staff received a variety of training to enable them to carry out their duties effectively. They completed a thorough induction programme when they first joined the service. The recruitment processes used to employ new staff were safe and ensured that staff employed had the skills, character and experience to meet people's needs. There were enough staff to keep people safe and protocols in place in case of shortages or staffing issues. The manager held team meetings and sent out staff surveys to provide staff with an opportunity to provide their feedback and contribute to the development of the service. Staff understood the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS) and these were applied correctly in practice.

There was a robust quality monitoring system in place for identifying improvements that needed to be made across the service. The service had formed strong links with the local community and had a team of volunteers and fundraisers who were an integral part of the home's culture and ethos. The environment was clean and well maintained with robust systems in place for monitoring health and safety and controlling the potential spread of infection. Equipment was regularly checked and there were contingency plans in place in case of emergency.

During the inspection we found that the service was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we've asked the provider to take at the end 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.

There were regular assessments and reviews of risks within the home, and staff demonstrated knowledge of how to keep people safe.

There were sufficient numbers of staff available to meet people's needs safely.

People's medicines were managed appropriately and stored correctly.

Risks to people were assessed and control measures were put into place to mitigate these as much as possible.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported through a regular programme of supervision and appraisal.

People gave consent to their care and staff understood their responsibilities under the Mental Capacity Act 2005.

People had enough to eat and drink and had their healthcare needs assessed and met by the staff.

Is the service caring?

Good

The service was caring.

Staff demonstrated a caring and friendly attitude towards people.

People were treated with dignity and respect and had their privacy observed.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which were personalised and evidenced involvement from people and their relatives.

There was a creative and full activity programme in place for people to engage in hobbies and interests inside and outside of the home.

There was a robust system in place for handling and resolving complaints.

Is the service well-led?

Good

The service was well-led.

People and staff were positive about the management of the service.

There was a robust quality monitoring system in place for identifying improvements that needed to be made.

Surveys and questionnaires were sent out to people, staff and relatives to encourage them to contribute to the development of the service.

Agate House - 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 over two days on the 19 and 21 March 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and asked for feedback from nine professionals involved with the service.

During the inspection we spoke with five people who used the service and three relatives to gain their feedback. We spoke with four members of the care staff, one member of the nursing staff, the activities co-ordinator, the domestic and housekeeping team leader, the health and safety lead, the deputy manager and the registered manager.

We observed the interactions between members of staff and people who used the service and reviewed the care records and risk assessments for four people who used the service. We checked medicines administration records and looked at staff recruitment and training records. We looked at complaints and

compliments received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. One person told us, "Yes it's a safe place to live." Another person said, "It's secure, there's always people around to help us and keep us safe. If I have an issue I let them know and they sort it out pretty quickly- they check everything all the time to make sure it's safe for us to use."

Prior to our inspection we received information that there had been some incidents in the service which had been the result of poor manual handling practice and had resulted in injury to people. The service had kept detailed records of these incidents and the outcomes of any associated safeguarding investigations. We looked at these and saw that the investigations were on-going but that the service had put measures into place to reduce the risk of recurrence. Staff had received training in safeguarding and understood the process to follow if they needed to report any concerns or felt people were at risk. There was a whistleblowing policy in place so that staff could report issues anonymously without fear of the consequences of doing so.

Manual Handling risk assessments were in place which detailed people's level of need when moving around the service and the measures taken to support them safely with this. Because of the disabilities of the people using the service, the registered manager told us that their procedures for moving and handling had to be robust. She said, "It's paramount that we get that right, we make sure they [staff] have in-house training regularly and that all our risk assessments are up to date." Details were listed of the type of equipment used, the potential constraints and risks of moving the person and the action needed to manage the process safely. The action plans formed from risk assessments were subject to regular review and detailed improvements that could be made to support people safely with moving. For example we saw that were it had been noted that one person was at higher risk while showering, the action plan determined that an extra harness should be used. We checked to see whether this action had been taken and noted that the equipment was now being used as identified. Mobility equipment and assistive technology including mobile hoists were subject to regular checks and there was backup equipment available in case of any failure. People had additional risk assessments in place for other areas of their care and support and these were personalised to their individual needs. There were personal emergency evacuation plans in place for people which detailed how each individual was to be moved and supported in case of an emergency.

The service had a robust and thorough system in place for monitoring the environment to ensure that it was safe. We saw that there was a programme of daily, weekly and monthly checks that were completed by the health and safety officers and the housekeeping and domestic staff. Any actions identified within these audits were quickly acted upon. An annual health and safety check was completed by the provider's head office and the service had been rated as 'excellent' following the latest audit. Fire checks, gas safety checks, PAT testing and water audits were all completed regularly. The service had closed for a few days in June 2015 due to a suspected outbreak of norovirus amongst people and staff. In response to this and to reduce the risk of recurrence the service had held discussions and provided extra training on hand washing and hygiene to remind staff of good infection control practices. We found that the service was clean with no malodours and that staff were taking preventative measures to control the risk of infection, including

wearing disposable gloves and washing their hands regularly.

People told us that there were enough suitably qualified staff available to keep them safe. One person said, "There's enough of them here, definitely. There's always someone about." However, we received some feedback about staffing shortages and recruitment difficulties which had led to extra pressure upon staff at times. One relative told us, "They are pressured. Sometimes [person] has to wait if they need two people to help them move." We discussed the issue with members of the staff team who felt that, whilst there were busy and pressurised periods, people were always kept safe. One member of staff said, "When people call in sick it can be hard sometimes. But we always get through and work as a team to make sure people get the care they need." We discussed this issue further with the management team who were able to demonstrate the ways in which they made sure that people had enough staff to keep them safe. Rotas were completed by the care supervisor which showed how staff had been deployed in previous weeks. We noted that there were 14 staff deployed on the morning shifts, seven in the afternoons and then an additional four during the evening, making seven during the evening in total. The night shift was covered by four staff including one nurse.

There was an emergency on-call system in place so that a senior member of staff could be called for cover in case of an emergency or serious shortage. The service made use of agency staff to cover shortfalls in staffing where necessary. We saw that these agency staff were subject to a formal induction and that the same staff were used whenever possible for consistency. During our visit we observed that call bells were in place for people to request assistance and that staff were able to respond to these within less than a minute when required. The registered manager said, "It has been tough at times but we've pulled through and we do keep people safe." She told us that a fifteenth member of staff was going to be added to the morning shift to relieve some of the pressure when supporting people to get up in the morning. Staffing levels were determined according to people's assessed needs. The high physical need of the people using the service meant that some required two or three people to support them when moving or transferring. This was reflected in their care plans and staffing levels were adapted accordingly to ensure that people were able to receive the required support at key times of the day. The service employed a large staff team with bank staff available in case of absences. Additionally, by using a pool of volunteers to take people out and spend time with them in the service, the care staff were able to focus on ensuring that people's daily tasks and personal care needs were attended to promptly and safely.

There was a robust recruitment policy in place to ensure that staff employed to work in the service had suitable experience, character and skills for their role. Staff were subject to an interview process that tested their competencies in key areas before being employed. We saw that there were two references on file for each member of staff from previous employers and that these had been verified by the service. Staff were asked to complete a DBS (Disclosure and Barring Service) check. DBS is a way for employers to make safer recruitment decisions and monitor whether staff have any prior convictions on their record.

People's medicines were administered safely. Nurses had full responsibility for administering people's medicines and received specialised training when they first began working with the service. In addition they completed a period of working with experienced nurses and underwent regular competency observations to support them to carry this out effectively. Nurses performed a monthly medicines audit which checked the stock levels, storage, booking in and return of medicines. An annual pharmacist advice visit took place to assess the safety of the medicines procedures in place. The service had acted upon the issues identified by these visits. For example we saw that where it had been raised that labels were not always being applied to eye drops once they had been opened, this had since been rectified. There were two separate medicines storage areas in the service which were kept at an appropriate temperature and accessible only to nursing staff. We checked the medicines kept in these areas and found that they were being stored appropriately,

stock levels were regularly recorded and the correct labelling and returns procedures were being followed. We observed nurses throughout the day with lockable trolleys and 'do not disturb' t-shirts and watched medicines being administered to people. We looked at MAR sheets for ten people and found that these were being filled out correctly with no unexplained gaps. This showed that people received their medicines as they had been prescribed.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive regular supervisions or performance reviews. We looked at four staff files and found that two new members of staff had not received a supervision since they began. Another member of staff who started in 2003 had last received a supervision in March 2012. A nurse who had been with the service since 2011 had received one supervision in the previous two years. There were meetings that took place with nursing staff to reflect on clinical practice but these were not supported by individual appraisals. The manager also carried out observations and out of hours visits to people to monitor their competencies and activity while on duty. For example we saw that night staff were subject to regular visits from the manager who provided feedback on the atmosphere and the quality of their recording. Staff told us that they felt supported by management but acknowledged that formal supervisions were 'infrequent', with one member of staff saying, "They happen every few months, or they're supposed to. I can't remember the last time I had one." There was no formal system in place for appraisal or performance review and staff were not receiving these in addition to their supervisions. Not holding regular appraisals meant that staff were not given feedback on their performance or competencies.

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

People told us they felt staff received the correct training to enable them to carry out their role effectively. One person said, "The staff have training- some have it when they first begin but the others go back for updates." Another person told us, "The staff are of a good standard for the most part, they know what I need."

Staff completed an induction programme when they first joined the service which included a structured week of working alongside experienced staff and attending classroom sessions to introduce them to the provider's vision and values. One member of staff said, "I had a good introduction into the service, I was new to care so learned a lot in that week." New staff were subject to a probationary report which monitored their progress during their first few months in post.

Staff received a variety of training which was regularly refreshed and updated. The staff we spoke with were positive about the quality of the training on offer, with one member of staff telling us, "It's all face-to-face training, we go to one of the company's other homes to do it. I've learned a lot." The care supervisor kept a record of the training that staff had attended and when they were due for updates. In addition to training that the provider considered essential, staff had opportunities to attend training in specialised areas. For example we saw that staff had attended training on person-centred care and diabetes. Nurses received additional training to assist them in their role within the home and were being supported to work towards revalidation. One member of staff said, "If I'm interested in any additional training then I'll let the manager know and she always sorts it out for me." Another member of staff told us they were completing their level 5 diploma in leadership and management.

Staff received training to understand the Mental Capacity Act 2005 and associated Deprivation of Liberty

Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had one DoLS authorisation in place and another going through the application process. The majority of people living at the service had capacity and those we spoke with told us they were free to leave as they wished and were not being unlawfully restricted. The one DoLS that had been put into place was appropriate to keep the person safe and their capacity had been assessed and had been followed by a relevant best interest decision.

People told us they consented to their residency, care and treatment. One person said, "I'm here by choice. I wouldn't go anywhere else. I can tell them what I want and if I ever needed to leave I would." Staff were able to describe the principles behind consent and we observed that people were asked before care or support was provided. Consent was further evidenced in care plans and people had signed to indicate their agreement with the plan being created, the information contained within them and the staff offering the support as detailed. There were consent forms in place for different aspects of their care; for example the use of audio/visual images or being supported with the administration of medicines.

People told us they had enough to eat and drink and enjoyed the food. One person said, "The food is nice. There's a good choice." Another person told us, "I'm not a big eater and they know that- if I don't want something they'll make me something else instead." Each person's care plan included a section called 'food, drink, diet and mealtimes' which listed the kinds of foods they enjoyed, any particular dietary requirements they had and their individual preferences around how they liked to eat. For example we saw that were one person enjoyed tea and other hot drinks in the evening, their care plan included the fact that they had a favourite mug they liked to drink out of. This information was then communicated to kitchen staff who planned menus and choices around people's individual requirements. We observed people being offered food and drink throughout the day. On one occasion we observed somebody asking if they could eat earlier as they were going out in the afternoon. The member of staff immediately went to the kitchen to request that the person's food be prepared for them at the time they had asked for. We observed people's mealtime experience and found that people had a healthy and nutritious lunch with varied options available. If people needed support with eating their food then staff sat with them to assist them. We observed that one person chose not to eat but was encouraged by a member of staff to have an alternative to what was available on the menu. Staff were patient and considerate when assisting people to eat and we saw choices being offered for both the main course and the desserts.

The service worked closely with other healthcare professionals in addition to the nursing that was provided onsite. A relative told us, "They take [person] for all their appointments when they need them." We saw that appropriate referrals were made where required to ensure that people maintained their health and had access to services that could support them with their conditions or changing needs. For example we saw where one person required a softened diet due to difficulty eating and swallowing. There were regular appointments recorded with the speech and language therapist to monitor their progress and action was taken on professional recommendations. People's healthcare conditions were listed in their care plans and included information on the medicines they took, their general health and what support was in place to monitor their condition. For example we saw that skin care and pressure ulcer prevention plans were in place for each person. Waterlow assessments were completed which determined the level of risk depending

on factors such as weight, malnutrition and mobility. This enabled the staff to monitor people's healthcare needs and make appropriate referrals as necessary.

Good

Is the service caring?

Our findings

People and their relatives told us that they were supported by staff who were caring and compassionate. One person said, "I absolutely love it here. Everything about it is wonderful. The staff are great." Another person told us, "The staff are lovely." A relative told us, "[Person] is very happy here." We received feedback from a professional involved with the service who said, "I have always found Agate House to be welcoming and vibrant- they have a number of volunteers who support a variety of activities and the residents have been involved with some local community projects."

The interactions between staff and people were kind and caring. There was an upbeat atmosphere in the service. Staff were engaging with people around them and asking them how they were and if they needed anything. We observed one member of staff checking that somebody was comfortable when they appeared to be in pain. A second member of staff was singing along with another person. One member of staff told us, "We treat them how we'd want to be treated. Just because some of these guys have disabilities doesn't mean they aren't just like you or I." Staff were able to tell us about people's histories and achievements. We observed staff using people's preferred names and talking with them jovially and respectfully.

People were treated with dignity and respect and had their privacy observed. We saw that staff knocked on people's doors and waited for permission before entering their rooms. Staff told us they would cover people up and close their doors when delivering personal care. We observed one person being supported by a member of staff to walk to their room. While moving the person asked, "Why are you walking with me?" The member of staff replied, "Do you not want me to?" and gently withdrew support.

The service had received a number of compliments from people and their relatives expressing their gratitude and appreciation for the care provided by the service. One such example read 'Thank you so much for making the transition from [person's previous placement] to your home so easy, sorting the paperwork and regularly reassuring me in the process. Since [person] moved in [they] have been so happy, [they] love the carers and they're always so caring, attentive and respectful with a smile on their face.'

A service user guide was issued to people when they first joined the service which gave people details of the nature of the home, the support available to them and key members of staff. There was a 'have your say' booklet given to people which detailed ways in which they could report or share any concerns or issues or make suggestions. Each person had their own key worker who worked closely with them to review their care plan, meet with them to discuss changes or updates and provided them with an opportunity for feedback. People knew who their key worker was and how they could provide their feedback if necessary. One person spoke warmly of how their key worker helped them with different parts of their life, saying, "They helped me go to a wedding recently, they'll help me with my shopping, they'll do anything for me." Another person told us, "I have a keyworker, they do anything I need and it helps to know I've got someone to speak to."

People had access to independent advocacy services if required. The registered manager was able to demonstrate that an independent mental health advocate had been sought on somebody's behalf to resolve a particular issue.

Good

Is the service responsive?

Our findings

People told us they had a care plan in place and were involved with its creation and review if they chose. One person said, "I know I've got one and they do try and get me involved, to be honest I'm not really interested but it's there if I need it." Another person said, "My [relative] deals with all that and they involve [them] in the reviews and meetings and things. I know what's in there and I know it's useful for staff to read to get to know what I'm all about."

Each person who came to the service had a new admission assessment form completed which looked at the key areas of support they required and was then used to create their care plan.
Each person had a 'one page profile' in their care plan which detailed the things that were important to them, what people liked about them and things that staff needed to know to support them effectively. We saw records included a list of people's likes and dislikes and their social histories and backgrounds. The care plans were divided into sections which included communication, routines, physical and emotional health and friendships and relationships. For people who had a learning disability in addition to their physical conditions, the service had sections which determined their level of cognition and understanding and how this impacted on them. We found that while plans were detailed and person-centred, there were not always many identified goals for people or evidence of how the service was supporting them to achieve these. Each care plan had a section entitled 'things I want to achieve in this area' which set goals and objectives for each person in key areas of their support but it was not always apparent how the service was working towards these. We discussed this with the registered manager who told us they were implementing a new initiative around future planning and intended to review this with each person in much greater depth. People told us they felt they did receive support to work towards their goals, with one person saying, "If I want to do anything, they make it happen. I don't need people to set goals for me, I know what I want and I'll tell them if I need help with it or not."

If people's needs changed then an update record was kept in each person's care plan with a section entitled 'what has changed?' We saw that when there had been incidents or significant changes in somebody's care and support, these were reflected in their plans and updated as necessary. For example we saw that where somebody had lost a significant amount of weight in a short space of time there were extra monitoring measures put into place to ensure that the person was eating and drinking enough.

There were daily notes in place which gave a basic overview of how people had spent their day, their level of engagement and activities they had participated in. Sometimes the information contained within people's daily notes was quite brief. We discussed this with the registered manager who told us they planned to introduce a more detailed template for recording. Staff also used handovers and communication logs to share significant information about people. An activities record was also kept for each person which listed what the person did, what worked and did not work and their level of engagement in each.

People told us they were supported to enjoy a range of activities, hobbies and interests in and out of the home. One person said, "I like to have the papers read out loud, they'll do that for me in the activities room." Another person said, "I like going round the garden, there's a volunteer comes and spends time with me and

takes me out. I love going to the stables and seeing steam trains." The service had a small team of activity co-ordinators who offered a dedicated, vibrant and creative programme of activity for people. The service had a room for activities which was open six days a week and offered a range of arts, games, crafts and an opportunity for people to engage socially. We spoke with one of the activity co-ordinators who was able to tell us about the ways in which they tailored the programme to meet the varied needs of the people who attended. They said, "Some of them like to have intellectual debates and others like to listen to nursery rhymes, so we have to adapt our approach to make sure nobody gets left out and they all have a good time." During the inspection we noticed that the activities room was busy and active on both days. The service had prepared for the Queen's birthday and St George's Day by creating a mural and encouraging people to think about how to celebrate their culture and nationality. In addition to enjoying the activities the room offered, people told us they could go out when they chose. One person said, "I have a lot of different places I like to go. I go out with my family, go on shopping trips, sometimes the seaside too." The service had a few different vehicles available to support people to activities outside of the home and we observed several people coming and going during the day.

The service had a procedure in place for handling complaints and people told us they knew who to complain to if necessary. One person said, "The boss, [name], she's the one to talk to if anything's up." Another person told us, "I'd take it up with the manager, but I've never made a complaint and don't think I ever will." The service had received one complaint and had taken decisive action to resolve this by holding a meeting with the complainant to discuss the issues raised. We saw that appropriate actions were taken to resolve the problems and we spoke with the family of the person involved to see if they were happy with the outcome. They said, "Since we've talked about it, things have been much better. I can't fault them for that; they've done what they said they were going to do." This showed that people's concerns and complaints were being listened to and resolved.

Good

Is the service well-led?

Our findings

People, their relatives and the staff team were positive about the management of the service. One person said, "I know who the manager is, [manager] is nice. Her door is always open." Another person told us, "I like her, she's nice. I would talk to her if I had a problem, sure."

The management team was made up of the registered manager, a deputy who assumed the supervision and line management of the nursing team and team leaders for each department including domestic, activities and the care staff. There were two health and safety officers who had responsibility for risk assessment and environmental safety. They worked closely with the domestic staff to ensure that people were kept safe. A care supervisor planned rotas and organised staff training. The structure of the service meant that there were staff dedicated to ensuring the efficiency, safety and development of each area of the home. Staff told us they felt the management team was supportive. One member of staff said, "The manager is approachable. I wouldn't have a problem going to her."

The provider's visions and values were listed as 'to assist people with disabilities throughout the world, regardless of their colour, creed or race, by providing the conditions necessary for their physical, mental and spiritual well-being.' Staff we spoke with were able to demonstrate knowledge of this visions and values.

Staff told us they had regular meetings to discuss issues around the service. One member of staff said, "We have about four or five of them a year, there's different meetings for different staff but it's good when we all meet as a home." We saw minutes from meetings that had taken place for nursing staff, night staff and the whole team. The issues discussed in these meetings were reviewed the following month and we saw that the manager had taken action to resolve the concerns raised. Staff were given opportunities to make suggestions for improvements, activities and feedback on concerns. A monthly newsletter was issued to staff with updates, reminders and important information. This helped to ensure that communication across the different departments of the service was consistent.

The registered manager utilised a number of audits to monitor quality around the service and identify areas that required improvement. A monthly 'walk around' audit monitored the service against the key lines of enquiry used by the CQC and identified actions that needed to be taken to resolve any problems or concerns. The provider held 'thematic reviews' which monitored quality in key areas. For example we saw that one thematic review had taken place in relation to infection control, while another had been completed to look at nutrition and hydration. Once the visit had been concluded the service was issued with a rating and given areas for improvement to concentrate on in future. The registered manager had used these reports to create action plans with set timescales for resolving each issue. The registered manager had also created an action plan which included the areas identified for improvement from their own audits and those which had been highlighted by a local inspection monitoring visit, which had rated the service as 'good'. We saw that action was being taken to resolve the issues which had been raised. For example where the monitoring visit had highlighted a lack of developmental goals for people, staff had been provided with additional training and new forms were being introduced to help people to set objectives for their future.

The service held residents meetings each month to give people the opportunity to provide feedback on issues affecting the service and make requests. We saw that the service took action to resolve these for people. For example where people had consistently expressed that they wanted to go out more, the manager had updated them with progress on buying new vehicles for the service. A new vehicle had been purchased in January 2016 and this had been communicated to people, enabling them to have more opportunities to go out.

Satisfaction surveys were sent out to people, their relatives and friends to gain feedback on the servicer and identify areas of concern. The last survey had been completed in 2015 but there had been a low response from people as many forms had been returned after the deadline. This meant that there was not much feedback and the registered manager explained that they were in the process of gathering feedback with a new survey. She was able to show us the template for this and told us that it had been sent out and that the responses would be collated once received. We did see that surveys had been provided to gain feedback on individual events; for example following the Christmas party in 2015 there had been questionnaires sent to people to ask how they had rated the experience.

Staff were also asked to complete surveys to provide their feedback on issues around the service. Feedback in some cases was quite mixed with some staff commenting on a lack of formal supervision and communication. We saw that the registered manager had quickly arranged a meeting in response to these issues and had discussed the impact upon the staff and what actions were being taken to resolve them. For example we saw that communication had been improved with the introduction of staff newsletters and that supervision training was being provided to team leaders.

The service demonstrated strong links with the local community through fundraising events and involvement from people using the service. There were several local businesses that regularly raised money for the service and the manager told us about the relationships they had cultivated with local shopkeepers, supermarkets and charities who provided both time and money to help support the people living in the home. Examples included a three-legged race which was held each year, cake stalls and fireworks events. The service utilised volunteers to spend time with people, take them out and develop further links with people outside of the home. This helped people to feel part of their wider community.

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 did not take formal enforcement action at this stage. 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 Staff did not receive regular appraisal of their performance in their role. Regulation 18(2)a