Methodist Homes

Maple Leaf House

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 16 December 2016. It was carried out by It was carried out by one inspector, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service

Maple Leaf Care Home provides nursing and personal care for up to 48 older people living with dementia. At the time of our inspection, there were 45 people receiving care at the service. There was a registered manager for the service at the time of this inspection. This is a person who has registered with the Care Quality Commission. They are responsible for the day to day management of the regulated activity of personal care at the service. Like providers, as a registered person they have a 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 inspection in June 2014 the provider was meeting the requirements of the Health and Social Care Act 2008 and related care standards.

People and relatives were confident of people's safe care at the service. The provider's staffing, emergency and contingency planning arrangements helped to ensure that people received safe care. Recognised incident reporting and safeguarding procedures were understood and followed when required to protect people from the risk of harm or abuse.

Risks to people's safety from their health conditions or environment were assessed before they received care. Identified risks were regularly reviewed and managed by staff who understood and followed the care actions required for their mitigation. People medicines were safely managed.

People were provided with the equipment they needed for their safe support. The environment and equipment used for people's care was regularly checked and maintained to ensure safe use.

People and relatives were happy with their care, often describing this as good or excellent. Staff understood people's health conditions and related care requirements, which their care plans showed.

People were supported to eat and drink sufficient amounts, maintain a well-balanced diet and access external health professionals when they needed to. Staff followed any related instructions for people's care when required.

Staff training arrangements were comprehensive to ensure safe, effective care delivery and related staff competency. Arrangements for individual staff supervisions were not being consistently maintained. Management improvements were assured to rectify this.

People were provided with personal care in line with legislation and guidance in relation to consent. Staff understood and followed the Mental Capacity Act 2005 to obtain people's consent or appropriate authorisation for their care when required. Care plan record keeping improvements were assured to consistently account for decision specific care in people's best interests.

People received care from staff who knew them well and were kind, caring and respectful. Staff understood and promoted people's choices, rights and comfort in their care. People and relatives were made to feel at ease and welcome by staff and they were involved, informed and consulted to help agree people's care.

People's care was individualised but not always timely. Staff were visible but sometimes did not observe or respond in a timely manner when people needed assistance.

Staff were usually mindful of people's needs. They supported people in a way that was meaningful and helped to reassure them when required. People were regularly supported to engage in social and recreational activities and practice their religious faith in a way they chose.

Environmental adaptations and equipment often helped to enable people's freedom of movement environmental engagement, orientation and recognition. Relevant specialist advice was secured to help inform service improvements to fully ensure this.

People and their families were confident and informed to raise any concerns or make a complaint. Their views about the service and those of staff were regularly sought and used to help improve people's care experience.

The service was generally well managed with a strong culture of 'staff teamwork.' People, relatives, staff and external stakeholders were confident in the registered manager.

Staff understood their roles and responsibilities for people's care and were informed and supported to raise any concerns about people's care or make improvements when required.

Regular checks were made of the quality and safety of people's care. Findings from this were used to inform, assure and make service improvements when required.

There were clear management arrangements and lines of reporting and decision making for the operation and direction of the service. The provider had sent us written notifications when required, telling us about important events that occurred at the service, in accordance with their legal obligations to us.

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 received safe care and support from sufficient staff. The provider's arrangements for people's care, equipment, environment and medicines helped to protect people from the risk of harm or abuse.

Is the service effective?

Good

The service was effective. People were supported to maintain and improve their health and nutrition in consultation with external health professionals when required. Staff followed the law to obtain people's consent or to provide care in their best interests when required. Staff were trained and supported to understand and deliver people's care in a way that met with nationally recognised practice standards. Arrangements for individual staff supervisions were not consistently maintained. Improvements were assured to rectify this.

Is the service caring?

Good

The service was caring. People received individualised care that took account of their rights and choices from staff who knew them well and who were kind, caring and respectful. Staff understood and promoted people's choices, rights and comfort in care. People and relatives were informed, involved and consulted to help agree people's care..

Is the service responsive?

Requires Improvement

The service was not always responsive. People received individualised care but not always timely care. Staff knew people well and ensured people's inclusion and engagement in home, family and community life. People and their families were informed and confident to raise concerns or make a complaint. Their views were regularly sought and used to make care and service improvements when required.

Is the service well-led?

Good

The service was well-managed and led with a strong ethos of teamwork. Staff understood their role and responsibilities for people's care. Management met their legal obligations and ensured regular checks of the quality and safety of people's care.

Findings from this were used to inform and make service improvements when required and enhance people's care experience.	

Maple Leaf House

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 was unannounced on 14 December 2016. It was carried out by one inspector, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before this 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 spoke with local community professionals and care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

We spoke three people, seven relatives and eight care staff including the chaplain, a cook and a visiting health care professional. We also spoke with the deputy manager and a senior external manager for the provider. We looked at six people's care plans and other records relating to how the service was managed. For example, medicines records and staff training and recruitment records, meeting minutes and the provider's checks of quality and safety.

As people were living with dementia at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Good

Is the service safe?

Our findings

People, relatives and staff felt staffing levels were sufficient to ensure people's safe but not always timely care. For example, relatives told us, "On the whole there is enough but they are sometimes rushed off their feet." "It's safe; there is usually more staff at lunchtime; which they need." Overall it seems safe but staff don't always have time to have conversations with people."

A few staff felt changes in people's health and related dependency needs were not fully considered by management, to help inform staffing requirements. Most staff felt that staffing was mainly sufficient unless there were staff absences for any reason. One staff member said, "There are odd days when there is not enough, which means we have to rush to provide people's care; which we don't like to do." Another said, "It's a good place to work but there is not always enough staff to spend time with people."

On our arrival there were two nurses and seven care staff with unplanned absence of two other care staff. Staff cover was sourced for this and secured by mid-morning. Management told us they aimed to provide two nurses and nine care staff throughout this day for the 45 people living at the home. Staff rotas from the 14 November to 14 December 2016 showed this was usually ensured with one nurse. Management advised that recruitment was in process for nurse vacancies, which records showed. A range of additional support staff were provided on a daily basis, including volunteers. For example, activities care staff and for catering, cleaning and laundry provision. The registered manager was also supported by a full time administrator.

During our inspection we saw staff were visible and prioritised people's care to help ensure their safety. For example, if people wished to move independently, but were unsteady on their feet or if people needed assistance to go to the toilet. We also saw staff supported people to eat, drink and take their medicines safely when required. This meant people were safely supported. At lunchtime we saw people were not always supported in a timely manner. We discussed this with management who agreed the use of a relevant staffing tool; to more accurately inform staffing requirements for periods of increased care activity.

Recognised recruitment procedures were followed to check staff, were fit to work in the home before they commenced their employment. For example, previous employment checks and relevant character references were obtained. Checks were also made with the government national vetting and barring scheme (DBS). The DBS helps employers to make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups of adults or children.

People's care plan records identified risks to their safety from their health conditions, environment and any the equipment used for their care. For example, risks from skin pressure damage or from falls. Peoples' care plans also showed the care actions required to mitigate those risks, which staff understood and followed. For example, we observed staff helping one person to move by use of specialist equipment. This was properly conducted in a way that helped to ensure the person's safety and comfort.

People's relatives felt people were safe when they received care from staff. One person's relative said, "Staff are brilliant; no hesitation about safety or reporting any concerns if I had them." We observed information

was displayed to inform people of their rights and how to keep safe. This included information about what to do if they witnessed or suspected abuse of any person receiving care at the home. Staff we spoke with knew how to recognise and report abuse and they were provided with related training and procedures to follow in any event. This helped to protect people from the risk of harm and abuse.

We observed the home was clean, tidy, well maintained and free from any observable hazards to people's safety. People's relatives said the home was always kept clean and fresh with no malodours. They also confirmed staff wore protective clothing when they provided people's personal care, which we saw during our inspection. For example, disposable gloves and aprons. This helped to protect people from the risk of germs through of cross contamination.

People were provided with the equipment they needed to ensure their safe support. For example, special seat cushions and bed mattresses to help to prevent skin sores; or mobility equipment, which staff needed to use to help people to mobilise safely. Records showed the environment and equipment used for people's care was regularly checked and maintained for people's safe use and support.

Where there was potential for medical emergencies to occur in relation to people's health conditions, there were clear procedures to inform staff how to respond, which staff understood. Staff also knew the provider's emergency procedures to follow in the event of a fire or other domestic emergency situation, such as a mains electricity power failure. This helped to ensure people's safety.

People's medicines were safely managed. People said they received their medicines when they needed them. We observed nursing staff gave people their medicines safely and in a way that met with recognised practice. Records kept of medicines received into the home and given to people showed they received their medicines in a safe and consistent way.

Nurses responsible for people's medicines told us they had received medicines training, which included an assessment of their individual competency. Related staff training records also showed this. The provider's medicines policy was subject to a periodic review and provided comprehensive guidance for staff to follow for the management and administration of medicines.

Good

Is the service effective?

Our findings

People and relatives were happy with the care people received, which they sometimes described as 'good' and occasionally so as 'excellent.' One person said, "They look after me." Another said, "I'm ok here." Relatives' comments included, "Staff are brilliant; if anything changes they get the doctor straight away." "My relative has been here for six months; I am very impressed with the care."

People's relatives, staff and visiting health professionals told us people were supported to see relevant external health professionals when required. For example, if their health needs changed or for routine health screening, such as eye or foot care. People's care plans reflected this and showed that staff followed any instructions from external health professionals relating to people's care when required. We spoke with a medical professional who regularly visited people at the service. They told us, "Staff are brilliant here and always on the ball; it's a good home. They [staff] are knowledgeable about people's health conditions and they work well with us." People's care plans showed people's health conditions, how they affected them and their related care needs, which staff understood and followed.

Staff received the training they needed to provide people's care which they described as 'robust' and 'comprehensive.' The provider's staff training records also reflected this. This included training specific to people's individual health conditions and their related care and safety needs. Where relevant staff knowledge and competency checks were routinely undertaken to help ensure correct practice was being followed for people's care or treatment when required. Some staff commented they had not received any formal one to one supervision with a more senior staff member for some time, which related records also showed. Management openly informed us that staff individual supervisions were 'behind' due to unforeseen absence of senior staff responsible. They showed us a suitable action plan to recommence and therefore rectify this.

Nursing staff said their training provision supported the required validation for their continued professional registration. Nurses were supported to undertake relevant extended role training, such as taking bloods or urinary catheterisation. Nurse lead roles were also established to help inform and support nationally recognised practice concerned with people's care. For example, dementia and end of life care; continence, infection prevention and control. Care staff were supported to achieve recognised vocational care qualifications and new care staff to undertake the care certificate. The care certificate identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

People were provided with care in line with legislation and guidance in relation to consent. 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.

We checked whether the service was working within the principles of the MCA. Staff had received training and they were aware of the principles of the MCA, which they understood and followed for people's care. During our inspection we observed where possible, staff sought people's consent to their care; they offered choices and explained what they were going to do before they provided people's care. People were not always able to consent to their care or make important decisions about their care and treatment because of their health conditions. Most people's care plans showed an assessment of their mental capacity and any specific decisions about their care and treatment when this needed to be provided in their best interests. Following our inspection management told us about the action they had taken to consistently ensure this. Related care records also showed appropriate consultation with their relatives and relevant health professionals where required. Some people had others who were legally appointed to act or make important decisions on their behalf; in relation to their health and welfare and/or finances. This helped to ensure people's rights and best interests in their care.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). For example, when people were not able to independently choose whether or not to live at the home. Records showed DoLS were either formally authorised by or requested from the relevant local authority. This showed people were received care with their consent or appropriate authorisation.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. A range of hot and cold food was provided at lunchtime. Portion sizes were tailored to meet people's requirements and there was very little food wastage. Food menus showed a choice of food and drinks were routinely offered throughout the day, which people's relatives confirmed and we also observed during the inspection. Most people ate in the main dining room and staff served meals to other people in their own rooms as they chose. Tables were set with linen cloths, crockery and glassware although condiments and napkins were not routinely offered in one dining area of the home. We referred this to management who told us they would take the action required to check and address this with staff as required.

Staff provided people with the assistance and support they needed to eat and drink. Staff helped people to eat at their own pace and provided them with gentle encouragement and support to do so. Staff knew people's dietary needs and preferences and followed instructions from relevant health professionals concerned with people's nutrition. For example, the type and consistency of foods to be provided, where risks were identified to people's safety from choking, due to swallowing difficulties. A choice of hot and cold meals and drinks were provided. People were also offered second helpings. People's meals were not always presented in an appealing or appetising manner. When people required their food to be a pureed consistency, the food portions which comprised the meal were over blended and presented in one portion on their plate, which was also too runny. For example, meat, vegetables and gravy were blended together rather than being presented on the person's plate in their separate portions. We raised this with management who agreed to take the action required to address this to enhance people's mealtime experience.

Good

Is the service caring?

Our findings

People and relatives said staff were kind, respectful and treated people well. One person said staff were, "lovely and kind." We received many positive comments from them, which included, "Always patient and caring." Wonderful patient staff; they always treat people properly." Feedback we received from people's relatives and results from the provider's most recent survey with relatives showed they rated the caring nature of the service as either good or excellent. One relative's written comment from the provider's surveys stated, "The highest praise to the care team; all the staff are very caring, helpful and respectful; nothing is too much trouble – staff are friendly, welcoming and approachable."

People and relatives felt at ease and welcome in the home. Relatives were appropriately involved and consulted in people's care. People's care plans showed their agreement to their care, as they were able to provide this and their know wishes, choices and preferences for their care. Staff we spoke with knew people well and understood what was important to people for their care, including their family involvement. One person's relative told us, "Staff are brilliant; they let me know if there are any changes; keep me up to date with how [person receiving care] has been."

Throughout our inspection we observed interactions between people, visitors and care staff were warm and good natured. One person relative commented, "It's so friendly and welcoming here." We found a relaxed atmosphere at the service where people's relatives and friends visited at times to suit the person receiving care. We observed staff were patient and caring in their approach, often took time with people and knew them well. For example, care staff consistently took time to understand and validate people's experience of living with dementia. They did this in a patient, caring and thoughtful manner that helped to reassure people if they became anxious or upset. Such as, if a person did not understand what was happening around them, how they needed to act or what to do.

Staff were kind, caring and compassionate. One person's relative was particularly satisfied with the care actions taken to help address the person's pain associated with their physical health condition. They said, "Staff have done their utmost to make sure they [person receiving care] are pain free and comfortable; it's given so much relief – they are exceptional." We observed when staff supported people to move; for example, to sit in another area of the home, they made sure people were comfortable and had a drink or other personal items to hand, which they knew were important to them.

We also saw staff were attentive to one person who showed they were experiencing physical discomfort from their shoe, which was causing soreness from rubbing. Staff took time to check with the person and fetched alternative footwear. On their return, the staff member made sure the person was happy and comfortable with the fitting. They also fetched the person a fresh drink to where they were sitting when this was completed. This was undertaken in a kind, helpful and reassuring manner by the staff member involved. The person smiled and visibly became more relaxed.

Staff understood the provider's stated care aims to ensure people's rights in their care. Related staff training arrangements helped to inform and ensure this. All of the staff we spoke with understood people's

individual rights, choices, daily living arrangements and care preferences. During our inspection we observed staff encouraged and supported people to make choices about their care, such as where to spend their time, what to eat and drink and often by encouraging people to do as much as they were able. We saw staff ensured people's dignity and privacy. For example, by closing bedroom and bathroom doors when personal care was being provided or by making sure people's clothing was properly adjusted. We observed staff sensitively supported people to take pride in their appearance; by helping them to choose clean comfortable clothing and footwear of their choice. One person particularly liked to wear items of their personal jewellery, which staff supported them to do each day. This showed staff considered and promoted people's rights and choices in their care.

A range of key service information was provided to help inform people's care. For example, this included what to expect, arrangements for choice and involvement and how to access independent advocacy services if people needed someone to speak up on their behalf.

Regular opportunities were provided for people's comfort and emotional support. This included sensory therapies such as reflexology and music therapy. A dedicated chaplain provided regular opportunities for spiritual counselling, guidance and support regardless of beliefs or faith.

Monthly newsletters were provided for people, relatives and staff to further inform and include them in home life. Management advised that key information could be made available in other languages or other alternative formats to aid people's understanding when required. For example, large print or easy read pictorial formats. We saw some of this was displayed in prominent places where people could see it easily. Such as pictorial information for people about social and recreational activities they could join. Photographs of staff were also shown with their names to help people know them.

Requires Improvement

Is the service responsive?

Our findings

People's care was individualised but not always provided in a timely manner. Relatives felt people received individualised care from staff who knew them well, but felt staff were sometimes 'rushed off their feet' and not always able to spend time with people. This view was also given by staff in our discussions with them.

Staff did not always observe or respond in a timely manner when people needed assistance. This mainly occurred at lunchtime where we observed people's mealtime experience in the main dining areas of each wing. For example, we observed staff did not provide one person with their meal for almost an hour and twenty minutes. During this time the person was sitting at a dining table with two other people who were provided with their meals at the same time. The person left sitting at the table without their meal was unable to communicate verbally because of their health condition. They became visibly restless and began to pull the corner of the tablecloth into their mouth. After a while one staff member tried for some time to gently dissuade the person from doing this; without any success until the person's meal arrived. At this point the person let go of the table cloth voluntarily and became visibly relaxed whilst staff supported them to eat and drink. However, others who had been previously seated at the table had finished their meals and left the dining area with support from staff to do so. This meant the person's mealtime experience was not such a pleasurable event for them.

We observed another person seated at a dining table who was unable to communicate verbally because of their health condition. Staff nearby who were busy helping other people with their meals, did not respond when the person raised their hand in the air for assistance with their 'runny' nose. We saw one person's mealtime was interrupted for several minutes on two occasions by staff who left them waiting. Whilst this occurred the staff member assisting them to eat their meal went to support other people elsewhere who needed assistance. This meant staff did not always recognise or respond to people's attempts to explain how they were feeling or provide their care in a timely manner when needed.

We observed staff were often mindful of people's needs and responsive to ensure people's timely care and support assistance when needed. For example, supporting people to eat and drink, to move or if they were upset or distressed. We saw a number of occasions when people became anxious or upset. Staff acted promptly to reassure and support each person in a way that was meaningful to them, which helped to reassure them.

One care staff member described how they supported one person living with dementia who could sometimes become anxious or confused. This was because they did not always understand what was happening around them. We saw the care staff member supported the person appropriately and in a way that was meaningful to them when this occurred. Another care staff member supported one person's independence by giving them 'finger' foods, which meant they could eat as they chose to walk around. This showed people's care was individualised and provided in a way that was meaningful to them.

Environmental adaptations were often made to support people living with dementia or with sensory of physical disabilities; to enable their environmental engagement, orientation and recognition. For example,

accessible memory boxes were built into the wall at the side of each person's bedroom door to aid their orientation to their own rooms. The boxes contained personal items that were meaningful to people, such as a favourite family or personal pastime photograph, an animal, favourite ornament or personal achievement award. Bold coloured crockery and contrasting colour tablecloths were provided, together with adapted eating utensils and drinking cups, which helped people's recognition and independence when they ate their meals. The home was purpose built on one level, with spacious wide corridors providing access to safe and accessible outside garden space. We saw this helped to support people's freedom of movement and to access fresh air when they wished.

We saw a number of improvements could be made to further support people's independence and environmental orientation and engagement. For example, we observed people asking for help on a number of occasions as there were no directional signs. Management advised of the provider's plan to review environmental provision following the recent appointment of an advisory lead. The advisory lead's role included informing any improvements that may be needed to ensure a dementia friendly environment.

People were supported to engage in a range of social and recreational activities within and outside the home and to practice their religious faith in the way they chose. Dedicated staffing resources and well-equipped facilities including dedicated room spaces helped to enable this. Daily and weekly individual and group activities were offered, which people were supported to engage in as they chose. For example, reminiscence, board games, crafts, exercise, music therapy and sensory activities. Entertainments, seasonal and themed celebrations were regularly organised, such as singers and performing artists, bonfire and birthday celebrations and vintage teas. People enjoyed a bonfire reminiscence day in the 'Coffee Shop' at the home. During our inspection local school children visited and sang Christmas carols to people in each of the communal lounges of the home. We also saw a number of people and their relatives enjoyed a visiting pantomime during the afternoon of our inspection.

People and relatives views about the service were regularly sought, listened to and acted on. This included regular meetings and periodic care surveys held with them. Recent meeting records and related action plans from this showed people's views were acted on. For example, to increase opportunities for people to access music therapy; garden areas and to address concerns raised about missing personal laundry items. Results from recent questionnaire surveys with people's relatives showed they were well satisfied with people's care provision at Maple Leaf House. All said they were likely or extremely likely to recommend the home to friend and family and gave many positive comments, which included, "All care and activities made life here so special"

People's relatives were appropriately informed and knew how to raise any concerns or make a complaint if they needed to. One person's relative told us, "It's an open culture; I have no issues or complaints; if I did, I know who to speak with - the manager, deputy, senior care staff; they all are helpful and they listen." Another told us, "Nearly five years on, the home is run to top class standards; I have never had cause to complain." Another said, "When we raised an issue with the manager, it was sorted straight away." Management records showed complaints were investigated, responded to and used to make improvements when required.

Good

Is the service well-led?

Our findings

People's relatives, staff, visiting health professionals and local care commissioners were confident in the registered manager and their management of the home. All often described the registered manager as supportive, helpful and accessible to them. We received positive comments from people's relatives. They included, "The manager is very open and accessible; it's a well- managed home;" "The manager is always around; she always makes time for you." Local care commissioners told us, "We have a positive working relationship with staff at Maple Leaf House, the manager is supportive, accommodating and highly understanding of people's needs and situations." Recent written comments by people's relatives from the provider's recent care survey included, "The home is run with great sensitivity and firmness by an extremely wise and approachable manager;" and "The staff team have a very good leader in the manager; who leads by good example." Staff described the registered manager as 'fair,' 'accessible' and 'always approachable.' One staff member said, "The manager is really supportive; you get a good work and home life balance."

Management told us they carried out regular checks of the quality and safety of people's care. For example, checks relating to people's health status, medicines and safety needs. This also included checks of the environment, equipment and the arrangements for the prevention and control of infection and cleanliness in the home. Checks of accidents and clinical incidence relating to people's health status were routinely monitored and analysed by the registered manager. For example in relation to falls, infections, skin soreness, medicines errors or people's nutritional status. This helped to identify any trends or patterns and was used to inform any changes that may be needed to improve people's care. Management also carried out periodic checks of nurses' individual registration status to make sure they were valid to give nursing care.

Management told us about some of the care and service improvements either made, planned or in progress from their recent management checks. For example, improvements to medicines and staff training record systems; improvements to staff deployment and supervision arrangements. Ongoing service development plans aimed to further enhance people's care experience through their environment, engagement and participation in home life. The provider's external management checks also monitored the quality and safety of people's care and improvements planned from this in consultation with the registered manager. This demonstrated effective management and the provider sought continuous service improvement.

There were clear lines of management accountability for communication, monitoring, reporting in relation to people's care and service provision and through to provider level. Staff said they were regularly asked for their views about people's care and they understood this and their roles and responsibilities for this. For example, they understood how to raise concerns or communicate any changes in people's needs. This included reporting accidents, incidents and safeguarding concerns. The provider's procedures, which included a whistle blowing procedure, helped them to do this. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their rights and how to raise serious concerns about people's care if they needed to. Records relating to the management and running of the service and people's care were accurately maintained and securely stored. The provider had met their legal obligations with us. For example, they had sent us written notifications when required telling us about

important events when they occurred at the service. For example, to tell us about Deprivation of Liberty [DoLS] authorisations. This helped to ensure accountability and continuous improvement for people's care.