Dudley Metropolitan Borough Council

Tiled House

Inspection report

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25 June 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18, 19 and 25 June 2018 and was unannounced. At the last inspection of the service in October 2015 we rated the provider as Good in all five of the key questions. At this inspection, we found that improvements were needed.

Tiled House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Tiled House provides an intermediate care and enablement service with accommodation and personal care for up to 47 people. The service cares for people who have been in hospital or suffered a crisis and need support to return to live at home in the community. The service provides short term support which can vary from weeks to a few months by which time people are independent or are referred to more long-term care provision. At the time of the inspection, there were 45 people living at 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

We saw people had to wait for support at times and staff did not always have the time to respond to people's needs in a consistent manner. Risks to people's safety such as falling, were identified and managed with steps taken to reduce risks. People were supported by staff who understood how to recognise and report abuse or harm. People received their medicines as prescribed. Staff understood their responsibilities in relation to hygiene and infection control.

People received care from staff that had the skills required to support them safely. Staff support and training was provided with further improvements identified. Most people liked the food, some people felt teatime and supper time choices were limited. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff gained people's consent before assisting or supporting them. People's health care needs were supported with access to on-site and external health professionals.

People were consistently positive about the caring attitude of the staff who they described as kind and caring. People were encouraged to regain their independence. People were treated with dignity and respect. However, staff did not always ensure information about people is treated confidentially.

People were involved in discussing their care and improvements were planned to provide a more detailed care plan. People had access to some planned activities and events to encourage their interests. People knew how to make a complaint and the provider had systems in place to manage complaints.

The provider's systems for monitoring the quality and safety of the service had not been effective in identifying shortfalls. Records held in relation to people's care were not always completed to ensure risks were managed. The analysis of falls needed to be more robust to help identify any trends or patterns such as the reasons people may be falling.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's care was at times delayed as staff were not always available to assist them.

People felt safe and were cared for by staff who understood how to recognise and report abuse or harm.

People's safety was assessed and staff knew how to manage risks to keep people safe.

Safe recruitment procedures were followed.

People received their medicines safely and as prescribed.

People were protected from the risk of cross infection as staff followed good infection control practices.

Is the service effective?

Good

The service was effective.

Staff understood how to support people's needs and had access to the training they needed.

People were supported to eat and drink and enjoyed the main meals but described tea and supper as limited in choice.

Staff gained people's consent before assisting or supporting them.

People's healthcare needs were met by on-site healthcare professionals to maximise their rehabilitation.

The facilities met people's needs in terms of rehabilitation, some redecorating was needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always ensure information about people remained confidential.

People described staff as caring and kind and people's dignity was respected.

People were involved in making decisions about their care and were encouraged to regain their independence.

People had access to advocacy services where required.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and rehabilitation goals. The development of more personalised care plans was underway.

People could be confident their complaints would be investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems had not been effective in identifying risks and had not been carried out consistently.

Records related to monitoring people's care were not always complete. The analysis of risks was not thorough.

People were asked for their feedback on the service.

The provider worked with key organisations to support people to receive joined-up care.

Tiled 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.

Our inspection was prompted in part by notification of two incidents in which there had been fatalities. Both incidents had been referred to external agencies such as the police and coroner. This inspection did not examine the circumstances of these incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of people at risk of falling. This inspection examined those risks.

This inspection took place on 18, 19 and 25 June 2018 and was unannounced on the first day and announced on the following two days. The inspection team consisted of two inspectors, a specialist nurse advisor, and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We reviewed information shared with us from the local authority health and safety officer. We spoke with 21 people who lived at the home and three relatives. As some people were unable to tell us their views of the service, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 23 staff which included the nurse and five of the therapy team [physiotherapists and occupational therapists]. We spoke with the cook, care staff, the registered manager, deputy and team manager.

We looked at the care records for seven people as well as nine people's medication records. We checked records held in relation to staff training, accidents, incidents, complaints and systems in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in 1 October 2015, we rated this key question as 'Good'. At this inspection, we rated this key question 'Requires Improvement'.

Whilst some people told us they were satisfied with the staffing levels we saw people had to wait for support at times because staff were very busy. One person said, "If I do buzz for them, they are pretty good and come fairly quickly". Another person told us, "I need to walk with a [member of staff], but they are always there to help me, and I don't have to wait". At times the demands on staff impacted on the time they had to respond to people. For example, we saw staff were moving between several care tasks and the continuity of care was interrupted so people waited for assistance to go to the toilet or have a drink. Some people said at times staff were too busy to assist them to walk. We saw at times staff were visibly rushed. A person told us, "Sometimes I feel very sorry for the staff; in the mornings they can be on their own for an hour, running around". A staff member said, "Sometimes we can't walk with people because there's no one in the unit so they have to wait". We saw dependency levels on each of the six units were reviewed and staffing increased where higher dependency levels were identified. However, although staffing levels were reviewed, there was no system in place to mitigate the impact of people having to wait for assistance on occasions, which may present a risk of people falling.

Prior to this inspection we had been made aware by the provider that two people had fallen and sustained serious injuries. At this inspection, we found the registered manager had taken action in response to the recommendations made by the health and safety officer and improved the systems in place to assess people at risk of falling. Falls risk assessments were completed for each person on admission to the service. We spoke with care staff who confirmed that people who were newly admitted should not be mobilised until the occupational therapist [OT] team had assessed them for any falls risks. A staff member said, "We don't walk people until they have been assessed by the OT and they write a card out and put it in the person's bedroom telling us what equipment can be used". We spoke with the occupational therapist team who informed us of recent changes to their practice. They confirmed that new systems had been put into place to ensure changes to falls risk assessments were updated. These were checked on a weekly basis by senior staff to ensure they matched the OT's recommendations. The registered manager said this system was working well and had helped to ensure changes to how people should be supported with their mobility were communicated. Staff we spoke with were aware of the risks to people who may fall and how they could reduce this risk. We saw they checked people had the right support to mobilise safely. For example, a staff member told us, "People who can walk independently with their walking frame have a green tag on their frame, a red tag if they need assistance". The OT's told us the colour tags system was a visual prompt to quickly identify people who may be walking when they needed assistance. They said they had good communication with the nurse who was visiting to advise them of additional factors that increased the risk of falling such as a water infection.

Risk assessments were in place for risks such as, pressure sores, weight loss, or choking. These showed the type of support people needed and the equipment to be used to assist the person safely. Staff we spoke with knew about people's individual risks and we saw staff were assisting people in line with their risk

assessment. Staff worked closely with several on-site health and social care professionals to meet people's needs safely. People we spoke with told us they were made aware how to reduce risks both during their stay and in preparation for returning home. One person told us, "I have discussed equipment I will need, and my home environment and I have practiced here".

People told us they felt safe at the service; one person told us, "I have been in here twice now and I have always felt that I am well looked after". Another person said, " "One thing that really makes me feel safe is seeing the pair of feet following me as I am walking. It gives me security and safety." Staff told us they had received training in how to safeguard people from harm or abuse and demonstrated they understood how to recognise or report any concerns. One member of staff told us, "I 'have had training and would report to a senior if I saw anything that concerned me". Safeguarding procedures were accessible to staff. We also saw people had information about reporting safeguarding concerns included in an information pack provided on admission. We saw that where safeguarding concerns had been raised, these had been acted upon and reported appropriately.

No new staff had been recruited to the service since our last inspection. Staff had transitioned over from other local authority establishments which had closed. The registered manager informed us that recruitment procedures were followed by the provider's human resources team prior to staff working at the service. Staff told us that the provider had sought references from previous employers and a Disclosure and Barring Service (DBS) to ensure they were suitable to work with people.

People told us they had their medicines when they needed them. We saw medicines were administered safely; staff checked the medication, gained consent, administered and signed records to show it was given. Medicine records were well maintained and checks on balances for some service user's medicines were found to be accurate. The storage and administration of controlled drugs [CD's] was managed appropriately. The CD register matched with the balance of medicines in the CD cupboard. Staff responsible for medicines had been trained. People were encouraged as part of the enablement process to be independent in administering their own medication. Capacity assessments were completed and lockable storage was available for people to store their medicine in their room(s).

There were systems in place to control and prevent the spread of infection. We saw the facilities were clean and odour free. Staff were observed to be wearing Personal Protective Equipment (PPE) when supporting people and understood their role in preventing the spread of infection. Staff had received food hygiene training but we saw one staff member handling a person's food without wearing gloves. This which posed a risk of infection and contamination.

We found that when things went wrong lessons were learned and shared across the team. For example, the registered manager had acted on the lack of falls risk assessments. They had ensured that all staff understood their role and responsibility in updating any changes in falls risk assessments.

Good

Is the service effective?

Our findings

At our last inspection in June 2015 we rated this key question as Good. At this inspection we found it remained Good.

People's needs were assessed prior to being admitted to the service. This focused on their medical needs, rehabilitation and their social situation. People told us they had some involvement in this process. One person said, "I came here to recover from a stroke; I've done really well with the help of all the staff". Another person told us, "I couldn't go straight home, but I walk unaided now and have made really good progress".

As part of the assessment the use of assistive technology and equipment was identified to ensure people's needs were met effectively. To promote people's independence and mobility, walking aids or aids to support people completing tasks independently were in place. We saw for example people's strengths related to managing their personal care were assessed. One person told us, "They assessed me on the stairs, crossing roads because of my vision, dressing myself and making drinks". Assessments of people's needs helped to ensure an effective plan of support was developed.

People were confident staff had the skills and training to support them. One person told us, "I have to use the hoist and the staff know how to do that and always lift me safely". Another person told us, "Yes, they understand how to help me; normally I walk with the frame but this morning I just couldn't get to my feet, so they used the hoist to help me". Relatives we spoke with told us, "The care is generally quite good; staff seem to know what they are doing". Another visitor told us, "They seem to know [name] well; she has ups and downs and they manage her meals and they make sure she won't fall when she's off her legs".

Staff confirmed they had access to training relevant to their role. Records showed some gaps in training, but we saw these had been planned for. Staff told us they did not have regular supervision in which to discuss their care practice. There was a large staff team with several staff having transitioned over to the service and staff individual supervision arrangements were being developed. We saw that the registered manager had tried to address this by providing group supervisions. The agenda for these showed that care practices and expectations were discussed so that staff worked to the same required standard. Some staff said they could seek and get support when they wanted this.

We found that staff who worked in the service all had varying degrees of experience in previous care settings. There had been no newly recruited staff, but staff confirmed they had an induction in which they shadowed experienced staff until they understood people's needs and were able to undertake care tasks independently. We found staff competencies were not consistently completed to ensure all staff had the skills and knowledge to support people effectively. Several staff were from an agency but there was no information as to how they were supported, or their competencies checked.

Whilst people were happy with the main meals but described supper choices as being less satisfactory. A person said, "The breakfast and lunch are good, but the tea is sandwiches, no choice at teatime and we don't get anything after tea". We followed this up with staff who confirmed that supper was variable;

depending on who was on duty. The cook told us teatime alternatives were available and varied and that staff had access to food supplies to ensure people had a supper. There were examples of the cook obtaining people's feedback and trying to improve people's options such as purchasing Quorn to encourage and vary the vegetarian diets. The feedback from people regarding their experiences at teatime and supper time indicated staff may not always effectively meet people's preferences.

People were asked about their preferences and diets related to their health, cultural and religious needs had been considered such as providing Halal meat. The cook was well informed about how people needed their food to be presented. We saw staff were attentive and supportive and ensured people had the right utensils to support their eating. Food was presented at the right consistency for people to eat safely. Regular monitoring of people's intake and the input of professionals such as speech and language therapist and dieticians helped to ensure people with complex needs were protected from the risk of poor nutrition or dehydration.

There was effective communication between staff via the daily 'handover' and communication books. Staff said they were aware of how to support people's mobility needs via information cards displayed in people's bedrooms which explained the equipment to use and the support to be provided. Staff told us a new initiative of marking people's walking frames with red or green stickers was effective in identifying quickly who could walk unaided with their walking frame. A relative said, "That's a good thing because you can see at a glance if someone should be assisted and get support".

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

We found that staff understood the need to seek people's consent and they consistently asked people before delivering care. We saw where people could not verbally give consent staff were aware of people's body language and gestures that would indicate they agreed to something. People told us that they had advice about their recovery from staff and the therapy team and had consented to the care being delivered to aid their recovery. One person told us, "I wasn't sure about coming here at first, but I am getting better, so it was a good decision". Where it was suspected people lacked capacity, an assessment was undertaken. No one currently had their liberty restricted under the DoLS, but the process was understood. For example, a person had previously experienced fluctuating capacity that put them and others at risk. In this instance a DoLs had been authorised to restrict the person's liberty such as keeping them under observation. Staff had all had training in the MCA and DoLs and told us if someone was subjected to a DoLs they would be informed to provide the right support.

People told us they had ongoing health conditions when they arrived at the service and that these were being met. One person said, "I need physio and I'm getting that here". Another person told us, "I see the nurse here for treatment and she does my dressings". The nurse confirmed she liaised with other health professionals if necessary. People had input from the on-site therapy team as well as external health professionals so that they had continuity of care. Staff told us if they were concerned about a person's health they would contact the nurse who visited the service, or the doctor. We saw two people were taken

poorly and appropriate action had been taken to seek timely medical treatment.

The premises were spacious with wide corridors which enabled people to mobilise safely when they used equipment. There was a large outdoor courtyard with seating and we saw people enjoyed sitting outside with their visitors. Each unit had a small kitchenette/dining area which people could utilise to socialise. The décor in some areas was tired and needed refreshing. One person commented, "The place could do with a lick of paint". Signage on doors helped people to find their way around the units and facilities such as toilets. New adaptations to the premises helped to meet people's needs because there were dedicated areas for people to undertake their physiotherapy and practice self-help skills such as cooking/climbing stairs. The facilities helped people's independence as they included hand rails and raised toilets which were easier for people to manage.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in June 2015 we rated this key question as Good. At this inspection we found it required improvement.

We observed occasions where staff did not ensure information about people is treated confidentially. For example, on each but one of the six units we saw people's care records were left unsecured and unattended. Several occasions were observed where staff spoke openly about people's care in front of other people/visitors or professionals. We saw lists on the walls for bed changes, and people's names which indicated their medical conditions and dietary records, and these were publicly displayed. The registered manager told us staff were aware of policies regarding confidentiality. However, this practice was clearly not identified by senior staff as needing action to ensure people's information was protected.

People were complementary about the caring approach of staff. One person said, "Staff are very nice and attentive; always enquiring how I am". Another person told us, "They all have my best interests at heart and I like them all. They are all very good".

We observed that staff were caring towards people. For example, one person was struggling to walk, and we heard they were panicking. The staff member gave lots of encouragement and reassurance; "Well done, don't worry we are with you we won't let you fall". Once the person was settled the staff continued to give praise and remind the person of the progress they had made. The person told us, "They are very patient; lovely girls always take their time and don't rush me". We observed a person was not feeling very well and saw the staff were caring and tactile in their approach.

People stayed at Tiled House for varying degrees of time depending on their recovery. Most people told us that they had developed friendly relationships with staff over time. People described staff as 'friendly' and 'supportive'. People told us that staff made time to talk with them and listen to them. One person said, "We have a chat and talk about our families and friends". Another person told us staff were supportive because they had listened to their anxieties about managing when they went home, they said, "I do worry, but staff tell me I'm getting better and I will get help you with that sort of stuff".

We saw staff communicate with people in a respectful and unhurried manner. They showed understanding of the difficulties some people might experience in expressing themselves. For example, we saw they encouraged a person who had a medical condition that affected their speech, to nod, shake their head or gesture when making decisions about what they wanted to eat or drink, or where they wished to sit. Other people confirmed they had choices about their care. One person told us, "Well the daily routine is much the same, but I do choose what I want and when". Another person said, "I was given information about my recovery and told it was up to me".

Some people told us how they had been supported to regain their independence, such as dressing themselves, making drinks and walking independently. One person said, "The physio is nice too and is helping me to walk; farther than I have in years!" Another person told us they had gained confidence in

crossing the road because they had support to be able to manage their sight impairment. People told us they were supported to identify the skills they wished to develop and had opportunities to practice these. One person told us, "I have got a lot better since I've come here but I do need to walk a bit more, but I haven't got a lot of confidence to walk on my own, the staff are helping me". Other people we saw had been supported to develop their independence by having regular exercises to build their strength to enable them to do things for themselves. Relatives were complimentary about the progress people had made and the positive encouragement people had from staff.

People we spoke with said they could advocate on their own behalf. We saw that where people required the use of an advocate this was identified so that decisions about the person's care or future care could be explored and their interests represented.

Visiting times were restricted and we were told this was so that people could undertake their therapies. We saw for example mornings were particularly busy with the therapy team visiting people and carrying out treatments. People told us they did not mind as they saw visitors later in the day.

People said that staff respected their privacy and dignity. One person told us, "Oh I have no worries; they are very respectful". People confirmed support was provided in the privacy of their bedrooms. We observed staff adjusted people's clothing when using the hoist so that their dignity was protected. Staff knocked bedroom doors and waited to be invited before entering. Another person told us, "They treat me with respect I was asked if I minded a man". Another person told us they liked to go to bed and this 'was not a problem'.

Good

Is the service responsive?

Our findings

At our last inspection in June 2015 we rated this key question as Good. At this inspection we found it remained Good.

People told us that they had been involved in discussing their needs to include their daily routines and preferences. We saw their choices were captured such as the times they liked to get up, go to bed and some information about their personal goals such as developing their mobility and regaining self-help skills.

Some people had the input of the therapy team and told us they had been asked about their level of independence and discussed ways they could be supported to regain skills. They confirmed that they received support from the therapists to carry out specific exercises. One person said, "Yes I do some exercises most days and a bit of walking; it's working because I am getting better". Another person said, "I lost a lot after my illness, but I am getting help here from the staff and help to get ready to go home". We found care plans included information about people's needs in relation to their health, mobility and communication. People's social situations had also been discussed and planned for to promote their return home and the ongoing support they would need. As part of people's discharge plan OT's could refer people for further support such as a shopping service, sitting service or meals on wheels. In addition, any adaptions or equipment needed in their home environment were planned for such as handrails or equipment to support their mobility.

Whilst plans were in place all the people we spoke with told us they had not seen a copy of their care plan. We discussed this with the registered manager. They told us they had organised a working group to develop a more personalised plan in one document that would capture people's personal information as well as the clinical input they received. This would enable them to have a document they could share with people.

We saw that staff had knowledge of the people they supported and responded appropriately. For example, they intervened when a person attempted to walk without their walking aid. We saw staff were aware of the usual character of people and saw they responded to a sudden change when a person was unable to swallow, recognising the person was unwell. People told us that staff knew them well. One person told us, "They know my routine and come and assist me at the times I need". Another person said, "I like to get up a bit later and they know that, they know what I like to do for myself and where I want help".

People confirmed they had been provided with support to develop their independence. For example, a breakfast club provided the opportunity to develop self-help skills. We saw that information was gathered about people's communication needs and the provider complied with the Accessible Information Standards (AIS). They had identified the type of disability or sensory loss a person may have such as following a stroke. The type of aids that might help people to communicate or receive information in a way they could understand had been identified. We saw for example that OT's could support people with such as reminiscence groups which could help people who had dementia. In addition, other aids for communicating such as picture cards, magnifying glass, pen and paper were considered. We did discuss the need to provide more detail to reflect this in people's care plans.

People had access to some planned and spontaneous activities such as bingo, music, quizzes and board games. These were not specifically personalised to enable people to follow the interests or hobbies that they pursued in their own homes. People's care plans included only limited information on their hobbies and interests. The sometimes-short term nature of people's stay created difficulties in accommodating hobbies. However, people did say some of the activities provided enabled them to try out new experiences. One person told us, "There is plenty going on, (shows a pom pom he has made.) I also made my friend a bead bracelet too. It is a simple thing, but it means a lot to me to have these new experiences". We saw some people watched TV or read the newspapers. Several people had formed friendships with their peers and told us they were happy enjoying their time chatting. There was an activities worker who arranged events and we saw a range of equipment such as crafts and board games, were available. Reminiscence groups, exercise sessions and planned celebrations also took place.

People said they would be confident in making a complaint. We saw they had been provided with an information pack which included guidance on how to do this which was available in people's bedrooms. The complaints procedure was also displayed in several languages for ease of access. There had been complaints made about the service and records showed continued dialogue between the service and complainants, reflecting attempts to resolve complaints. The registered manager showed us a monitoring tool they used to review complaints with a view to improving the service to people. However, this did not contain actions which might be needed to reduce the likelihood of re-occurrence. For example, there had been a drugs error but a competency checks on the staff member involved was not undertaken to identify the reasons for this or how it could be avoided.

As an enablement service it is not intended that people will require end of life care. However, the provider had sought information in relation to any decisions people may have made such as Do Not Resuscitate [DNAR]. This enabled them to act on people's wishes where this might be needed.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June 2015 we rated this key question as Good. At this inspection we found it required improvement.

We found that the provider's auditing processes and governance were not always effective in monitoring and responding to risks to people's safety. For example, the provider had not identified a shortfall in written falls risk assessments. This had been identified as part of an investigation by an external professional after a serious incident. The provider had now taken steps to improve this and ensure falls assessments were completed appropriately. However, these improvements needed to be sustained.

We also found the monitoring and analysis of falls needed to be more robust. For example, we saw there had been several falls at night but there was no record to show if any trends had been identified. For example, the times of falls, who was on duty, the place people were falling. This could provide insight into possible high risks times where people are more likely to fall. We discussed this with the registered manager who told us they would review the way they monitored falls.

The governance arrangements in place were not consistently followed. For example, we found for a person that staff had not consistently completed re-positioning charts to show that the person had received the correct pressure relief they needed. This was not picked up by the auditing processes and could compromise people's safety.

The registered manager acknowledged that there were shortfalls in their systems to assess the quality of the service. They informed us management team sickness had impacted on their ability to carry out audits. However, this had recently improved due to two new senior staff in post. We saw more recent audits were in place and had been effective in relation to identifying where improvements were needed. For example, we saw care plans were being improved to ensure they were more detailed and personal to the individual. Medicine audits had identified shortfalls in relation to medicine management and these had been addressed; for example, ensuring medicine records were signed and written protocols were in place for when people needed their medicines. Audits for the safety of the environment were evident and showed regular checks were carried out and action taken such as repairs and replacement of equipment. A review of any safeguarding concerns and complaints identified any actions to be taken.

We found that staff did not receive regular supervision in which they could reflect on and develop their practices. The registered manager had introduced group supervisions to ensure everyone worked to the same standards. However, we saw examples of where staff were not consistently working to the required standards. For example, in relation to maintaining people's records and confidentiality. These practices had not been identified by management which indicates staff are not clear about what they need to do to improve. Staff told us that checks on their performance and practice were not regularly carried out.

People and relatives said the service was well run and provided them with the service they needed. One person said, "It seems pretty organised; foods alright and staff always around to help". Another person said,

"It's the right place for me to be to get better and get the help I need".

We saw staff had a clear understanding of the service's vision; to provide enablement and care to people recovering from an illness. One staff member told us, "Our aim is to help people get better, stronger and hopefully go home". Another staff member said, "We work alongside the therapy team to rehabilitate people, sometimes they are very poorly or weak but it's lovely to see them get better". An OT told us, "We share the same aim, we work as part of multi-disciplinary team [MDT] and meet regularly to review people's care needs and discharge plans".

We saw people and their relatives had been provided with opportunity to feedback on their experience of the service. This was done via questionnaires and residents' meetings. The provider's analysis of the questionnaires had not yet been completed but we saw people's comments were in the main positive. These showed people were happy with a range of areas such as staffing, meals and how they were cared for. Improvements to the activities on offer were identified and the registered manager told us they would have an action plan to address this. There were several compliments, thank you cards and letters from people demonstrating positive experiences of the service. The registered manager told us they tried to operate a positive culture and an open-door policy by conducting regular walk-around and speaking with people. However, there were no records to capture people's perspective of the quality of the service on a day to day basis and people told us that they were not familiar with the registered manager. A person said, "I have never spoken to a manager I have no idea who that is".

Staff knew about reporting safeguarding concerns and were aware of how to whistle blow if they were unhappy about people's care. The provider was aware of their responsibility to notify us and other agencies about events to ensure appropriate action is taken to safeguard people. This approach helped to support an open and transparent culture within the service.

The provider worked alongside several care professionals from the multi-disciplinary team [MDT]. This enabled them to work together for the interests of people using the service. For example, they communicated with social workers in relation to discharge plans for people going home. They also worked alongside the therapy team to ensure people had the resources needed to support them safely within their own home. There were regular MDT meetings which helped to coordinate services people would need so that they had continuity of care.

Providers are required to display their most recent rating from our CQC inspection report and we saw that they had met this requirement.