Durham Care Line Limited

Nevilles Court

Inspection report

Darlington Road
Nevilles Cross
Durham
County Durham
DH1 4JX

Website: www.carelinelifestyles.co.uk/our-homes/nevilles-court-durham

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13 July 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 July 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Nevilles Court on 17, 18 and 21 July 2014 and informed the registered provider they were in breach of two regulations: care and welfare of people who use services and; assessing and monitoring the quality of service. The provider submitted an action plan in February 2015.

Whilst completing this visit we reviewed the action the registered provider had taken to address the above breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the registered provider had ensured improvements were made and that they were compliant with the relevant regulations. We found the registered provider had ensured improvements in three areas previously rated as requiring improvement.

Nevilles Court is a residential home close to central Durham providing accommodation and personal care for up to four people with learning disabilities and/or physical disabilities living in their own apartments. There were four people using the service at the time of our inspection, although one person was in hospital at the time for a scheduled review.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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 that, since the last registered manager had left the service, the registered provider had recruited two interim managers who had since left the company. The current manager was going through the process of applying to be registered with CQC.

There were sufficient numbers of staff on duty in order to safely meet the needs of people using the service and to maintain the premises. All areas of the building were clean.

Staff were trained in safeguarding and displayed a good knowledge of safeguarding principles and what they would do should they have any concerns.

People who used the service and their relatives expressed confidence in the ability of staff to protect people from harm.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service checks, references and identity checks.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). There had been particular improvements in

relation to topical medicines (creams).

Risk assessments had also been improved and staff displayed a good knowledge of the risks people faced and how to reduce these risks.

People received the treatment they needed through prompt and regular liaison with GPs, nurses and specialists.

Staff training had been updated to ensure staff had a good working knowledge of people's physical needs. Staff had also received refresher training in areas the provider considered mandatory, such as safeguarding, risk assessment, fire safety, first aid, epilepsy awareness and infection control.

Staff received regular supervision and appraisal processes as well as regular team meetings.

We checked whether the service was working within the principles of the MCA. Staff displayed a good understanding of capacity and consent and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was relaxed and welcoming. People who used the service, relatives and external stakeholders told us staff were patient and dedicated and we observed staff interacting with people in this way.

Person-centred care plans were in place and people pursued hobbies and interests meaningful to them with the support of staff. We saw regular reviews took place with the involvement of people, their family members and advocates.

Staff, people who used the service, relatives and an external professional we spoke with had confidence in the staff team, the care manager and the compliance manager. We found the new manager had yet to gain an oversight of the service and the role of team leader was currently vacant. The compliance manager assured us this role would be filled.

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.

Risks to people were assessed and individual plans were in place to help staff reduce these risks. Staff displayed a good knowledge of the risks people faced.

Staff knowledge of safeguarding responsibilities and procedures was good.

Improvements had been made in the administration of medicines, which we found to be safe and effective.

Is the service effective?

Good

The service was effective.

Staff had received a range of refresher training to keep their knowledge current, as well as specific training to meet the changing needs of people who used the service.

People's medical needs were met through access to primary and secondary health care services.

Consent and choice was considered throughout care planning, with the compliance manager and care manager showing a good knowledge of the principles of the Mental Capacity Act (MCA).

Is the service caring?

Good

The service was caring.

People who used the service, their relatives and one person's advocate praised the caring approach of staff and we observed patient and dignified interactions during our inspection.

Staff adjust their communication styles to meet the varying needs of people who used the service.

Care plans were written with the involvement of people who used the service. The registered provider had regard to people's best interests by liaising with family members and other

advocates.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and a keyworker system successfully ensured staff had a good understanding of people's needs.

Staff sought advice from healthcare professionals and incorporated this into care planning.

The service actively encouraged complaints as a means of encouraging improvements in practice.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not have a registered manager in place and the new manager did not yet have a good understanding of people's needs. We found the leadership of the service still required improvement.

Quality assurance and auditing systems had been improved and were effective in making positive changes to the service.

People who used the service, their relatives, staff and external professionals we spoke with described management and staff as approachable and accountable.

Nevilles Court

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.

We visited the service on 12 and 13 July 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking with people and observing interactions between staff and people who used the service. We spoke with two people who used the service. One person who used the service was in hospital for a scheduled review whilst one other person using the service did not want to speak with us. We also spoke with three relatives of people who used the service and one advocate. We spoke with six members of staff: the compliance manager, the care manager the manager and three care staff. Following the inspection we spoke with two district nurses.

During the inspection visit we looked at three people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, quality assurance systems, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. No concerns were raised regarding the service by these professionals.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faced and any improvements they planned to make.

Good

Is the service safe?

Our findings

People who used the service, their relatives and external professionals we spoke with expressed confidence in the ability of staff to provide care safely. One person told us, "I have no problems – there are no bothers like that." One relative told us, "[Person] is very safe there because they know [Person] well." One external healthcare professional told us, "They have no issues at all in terms of safety."

At the previous inspection of 17 July 2014 we identified concerns about the standard of risk assessments in place. We reviewed risk assessments at this inspection and found them to be clear, accurate and specific to individual need. Staff were aware of the specific risks faced by people and how they should reduce these risks by following the actions set out in the risk assessments. For example, one person was at risk of tripping and we saw there were risk assessments linked to care plans which set out how staff should help the person reduce this risk. This included removing clutter from communal areas, as well as having regard to potential risks when out in the community.

At the previous inspection of 17 July 2014 we found staff knowledge of the choking risk one person faced required improvement. At this inspection we found these risks assessments to be up to date and incorporated recent advice from external healthcare professionals. When we spoke with staff they displayed a good knowledge of the risk the person faced and how to minimise that risk.

At the previous inspection of 17 July 2014 we identified that the administration of topical medicines (creams) was not explained in the medication policy. We reviewed the medication policy during this inspection and found it to be clear in its guidance to staff regarding how to administer topical medicines. When we spoke with staff they displayed a good knowledge of people's topical medicines and how to apply and record them through the use of a body map. Staff explained the risks associated with not adhering to this procedure and how they ensured people were kept safe.

The storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's medical records contained their photograph (where people had consented), any allergy information, emergency contact details and instructions regarding how they preferred to take their medicine. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors.

With regard to 'when required' medicines such as paracetamol, we found there was detailed additional information in place explaining when this might be required. Staff displayed a good understanding of the 'when required' medicines people used and how they would communicate the need for such medicines to staff.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a locked cabinet and a locked fridge was also in use. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits. This demonstrated people were not put at risk through the unsafe management of medicines.

Staff displayed a clear understanding of safeguarding and were able to describe the risks of abuse people might face and how they would respond if they felt this was the case. We saw that staff had received safeguarding refresher training since our last inspection and knew how to contact the local safeguarding team.

We found there were sufficient staff on duty to meet the needs of people who used the service, with two carers on shift during the day and night and a care manager or home manager (both of whom currently worked at two sites) on duty during the day. People who used the service, relatives and staff all told us they felt there were sufficient staff to meet people's needs. This meant people using the service were not put at risk due to understaffing.

We saw one member of staff had joined the team since the last inspection and that the appropriate pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw the compliance manager had asked for at least two references and had verified the new staff member's professional certification. The compliance manager also ensured proof of identity was provided. This meant the service had a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found all areas of the building, including people's bedrooms, bathrooms, kitchens and communal areas to be clean and free from odours. People who used the service and their relatives raised no concerns about the cleanliness of the service. One relative stated, "We visited regularly and it's always clean," whilst another stated, "They keep [Person's] room spotless." This meant people were protected against the risk of infections.

We saw staff undertook regular environmental checks of the building and that any maintenance issues were reported and addressed promptly. We saw Portable Appliance Testing (PAT) and periodic electrical testing had been undertaken. The fire alarm and emergency lighting were tested regularly, whilst fire extinguishers had been serviced and window restrictors were in place. Fire doors were regularly checked as were emergency exits to ensure they were free from clutter. Water temperatures were regularly checked to ensure people were not at risk of scalding, whilst a periodic legionella inspection had been scheduled and we saw evidence shower heads had been regularly disinfected and descaled to protect against the risk of water-borne infections. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were clearly documented and recorded in such a way that made it easy to identify and trends that might develop. We saw there had been no major incidents or accidents since our last inspection.

We saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. These were easy to follow and easily accessible. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

At the inspection on 17 July 2014 we raised concerns that staff were not trained to be aware of the specific needs of two people who used the service. At this inspection we saw specific training had been delivered regarding these physical conditions. We saw staff had attended training and that the topics were also discussed at staff meetings. When we spoke with staff they displayed a good awareness of the physical conditions and the impact they had on people who used the service. Likewise, when we followed this matter up with a visiting healthcare professional they confirmed, "Their knowledge is good in terms of [condition] and if you give advice they follow it." This demonstrated the registered provider had ensured training relevant to people's needs, which had not been in place at the last CQC inspection, had been successfully delivered and that people received care from staff who had the suitable knowledge to do so.

At the inspection on 17 July 2014 we identified that staff were not trained in Positive Behaviour Support (PBS) and that one person who used the service could sometimes behave in a way that staff found challenging. We saw this person had since moved to a different service but that staff had had attended PBS training and were scheduled to have further PBS training. PBS is an approach that is used to support behaviour change in people where this may be needed. Staff we spoke with displayed a good knowledge of the principles of PBS and were able to explain how they would use the technique in future should people's needs require.

Staff training was well managed and we saw the compliance manager used a matrix to track who was due to refresh certain training courses. Since our last inspection we saw all staff had received a range of refresher training that equipped them to help meet people's needs, for example, Management of Actual or Potential Aggression (MAPA), Epilepsy awareness, medication administration, first aid, dementia awareness, oral healthcare, infection control, risk assessment, safeguarding, fire safety and Control of Substances Hazardous to Health (COSHH).

Where people's needs changed we saw staff had been trained so they could continue to provide good levels of care to people. For example, one person's physical needs changed, meaning they required percutaneous endoscopic gastrostomy (PEG) feeding. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. We saw staff had received training in how to support the person and we also saw all related care plans and risk assessments had been updated. One external healthcare professional we spoke with stated, "The PEG feed regime they have is good." All staff we spoke with were able to describe how they supported the person, in line with the relevant care plan.

People who used the service were complimentary about staff, stating, "They are really good," and, "They're fine with me." We saw there was a keyworker system in place and, when we spoke with staff we found them to have a detailed knowledge of people's healthcare and other needs. Relatives we spoke with told us they had confidence in staff, with one relative stating, "Staff are accountable and approachable." One relative singled out the person's keyworker and stated they were, "Excellent. They really know what they're doing." One person's advocate told us, "It's very appropriate at the minute – they are meeting [Person's] needs."

This demonstrated staff had a good knowledge of the needs of the people they cared for.

We saw staff incorporated and adhered to advice from external professionals. We saw advice from Speech and Language Therapy (SALT) professionals had been added into people's dietary care plans and risk assessments. We also saw advice from an occupational therapist had been incorporated into one person's care planning with particular regard to their mobility whilst out in the community.

We saw people were supported to access health care services such as GP visits, dentist appointments, hospital reviews, optician appointments and chiropody services. One relative confirmed, "They arrange [Person's] appointments and go with them to the doctor's."

We saw staff communicating with people well and saw staff used recognised tools to support this. For example, staff used the Disability Distress Assessment Tool (DISDAT) to help identify when a person who was unable to verbally communicate well was experiencing distress. The DISDAT tool helps identify distress in people who have limited communication abilities. We found this tool had been completed in detail and when we asked staff about how they would interpret non-verbal signs from people who used the service, these were in line with the information contained in the tool. This demonstrated that staff communicated well with people who used the service.

Staff confirmed they had regular supervision and appraisal meetings and we saw evidence of this in personnel files. We also saw evidence of regular staff meetings, at which topics such as safeguarding were discussed.

With regard to nutrition we saw people were involved in preparing their own meals. People told us they went shopping regularly with staff and were able to choose their preferences. Staff displayed a good knowledge of people's dietary requirements and one person's advocate told us, "They praise [Person] about their cooking skills to encourage independence." We saw one person had received input from the district nurse and a GP, who regularly monitored their cholesterol. Staff were aware of this and encouraged the person to choose healthy alternatives when they went shopping, although this was not always successful. The compliance manager and care manager agreed this encouragement could be improved by ensuring they could offer more specific 'like-for-like' examples for the person. We saw they had offered the person an alternative to bought cheesecake by offering to help the person make a lower fat version in their apartment. The compliance manager acknowledged the support they gave to this person to choose healthier alternatives could be improved further.

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).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The care manager and staff we spoke with demonstrated a good understanding of the principles of the MCA and the importance of DoLS. For example, we saw people's capacity was assessed on a decision-

specific basis, rather than blanket decisions being made about people's capacity. We also saw appropriate documentation had been submitted to the local authority regarding the DoLS. The advocate we spoke with confirmed they were regularly involved by the service to make sure one person's best interests were considered. Likewise, one relative told us, "We are [Person's] voice and they listen to us."

Good

Is the service caring?

Our findings

People who used the service told us they, "Got on well" with staff members and we saw keyworkers had formed strong bonds with people they cared for. One person said, "I like the staff. They are good with me." Relatives we spoke with were consistently positive about the caring attitudes and commitment of staff. One told us, "It's an ideal place for [Person] because it's small and they get plenty of attention." Another relative said, "[Person] loves being there – it's really homely and staff always give us a drink." One person's advocate told us, "The support [Person] gets from the keyworker is very good – there's a strong relationship there, which has really helped them."

With regard to continuity of care, whilst we noted the turnover of the management position had been high, care staff had remained consistent and people and relatives told us this had a positive impact on them. One relative said, "We see the same staff regularly – [Person] knows the staff so well now and feels at home." This meant the registered provider had developed and maintained a good continuity of care for people who used the service, meaning they were more able to feel at home and comfortable with staff who provided care.

We observed people interacting with staff in a comfortable and relaxed manner and staff sharing jokes with people. We found the atmosphere to be welcoming and the culture to be caring and one where staff welcomed individual accountability.

With regard to people's dignity, we found staff treated people with respect and care plans were sufficiently detailed to ensure people's personal care needs were appropriately met in line with their wishes. For example, we saw one person required prompts to ensure they maintained levels of personal care. We saw this was recorded in the person's care plan and that there were clear instructions for how staff should do this subtly to maintain the person's dignity. When we spoke with the persons' advocate they confirmed, "They managed [Person's] needs subtly and praise and prompt when they should do." During our inspection we saw staff treating people in a dignified way, for example knocking on their door and waiting for a response before entering.

We saw people's consent had been sought for all aspects of care planning and where consent was not given, for example, to take a photograph, this was respected. We saw one person had initially not consented to giving 'next of kin' information to the service. Staff had respected this but then explained to the person why they needed the information and the circumstances in which it would be used. The person had then consented to sharing this information.

We saw staff communicating with people who used the service well and adapting their style accordingly. For instance, one person who used the service struggled to understand long sentences and could retain information better if staff repeated information to them. We saw this was accurately recorded in the persons' care plan and staff spoke to the person in this way during the inspection, using short sentences, pausing before moving on and repeating where necessary to ensure the person understood.

We saw rooms were personalised and decorated in varying styles to meet the preferences of people who used the service. For example, one person had a range of photographs and football memorabilia. One person used the Internet to use social media and join online forums about their physical condition and we saw their room was suitably arranged for them to use a computer desk comfortably.

We found care plans to contain good levels of information regarding people's likes, dislikes and personal histories. When we spoke with staff they were able to tell us about people's needs and preferences in detail.

We saw people's personal sensitive information was securely stored in locked cabinets and on a password-protected computer system, in line with the confidentiality policy.

We found key documentation such as the welcome pack for people who used the service and the complaints procedure was available in easy read format. We also saw recent reviews of the medication policies had introduced easy-read sections regarding the administration of certain medicines, such as eye drops or an inhaler. The compliance manager told us this was with a view to giving people the opportunity to self-administer some medicines in future.

Good

Is the service responsive?

Our findings

At the previous inspection of 17 July 2014 we raised concerns about people not being able to use their car as regularly as they would like due to a lack of staff – this had meant a person waiting a number of days for a staff member to become available to drive them to their chosen destination in their car. At this inspection we found improvements had been made. One person who used the service told us, "That has been the one frustrating thing but it has got better recently." They confirmed they liked to go out in the car twice a week when the weather was fine and that this was now regularly happening. We saw the care manager had regularly been on shift to provide adequate cover for other people who used the service when one person chose to go out in their car.

At the last inspection we found staff had not pro-actively encouraged people to try meaningful activities. At this inspection we found there had been improvements. For example, one person who had a range of mobility complications had been a keen competitive sportsperson years previously. We saw staff had acted on advice of an occupational therapist, consulted with the person and their advocate and put in place a programme of staff support to ensure the person could regularly attend the gym. We spoke with this person, who told us they enjoyed going to the gym and that it was important to them. This person's advocate told us they had been pleased with the level of personalised support provided, stating, "It's only small but it's quite innovative in what it offers - they provide a good level of independence."

When we asked the compliance manager about how they ensured people received such outcomes they told us they were introducing the 'Life Star' model. Life Star is a behavioural recovery model intended to support people to improve their independence or other goals. We saw this had not yet been introduced and could not therefore see evidence of any positive impact it might have. Staff were able to demonstrate however through the existing tailored care plans that they supported people to attain person-centred goals through their care planning.

We saw care plans were detailed and written in a person-centred way, focussing on the needs of each individual. Each contained the person's photograph and explained who their keyworker was. We saw each person's care planning was made with the benefit of access to information from external health and social care professionals, and people's family or advocate.

People were protected against the risk of social isolation by being supported to take part in the activities they preferred and through regular contact with family members and advocates. For example, one person went to a hydrotherapy session once a week, whilst another person went to the gym, read books and enjoyed classical music.

We saw staff identified where people's needs changed and sought help from a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. Staff supported people to meet these appointments in a sensitive way. For example, one person was uncomfortable with the venue of their regular assessment with a consultant due to the negative experience they had suffered there previously. Staff liaised with the consultant to ensure they could visit the person at their home and we saw the person

was described as much less anxious as a result.

We saw people's views were regularly sought through surveys and care reviews. We saw the compliance manager had recently issued this year's service user surveys but had not yet received the results. We saw the previous survey had led to specific actions in response to people's comments, such as redecoration of rooms. One person had asked if it was possible to have a garden and, whilst we saw there was no provision for this at the location, the person had recently visited the botanical gardens, which they told us they had enjoyed. One person described the social activities provided as 'average' whilst the other people who used the service described the activities as 'good'. When we spoke with people who used the service they spoke positively about the activities they pursued.

Reviews of care plans were held regularly with the involvement of people who used the service and their relatives or advocates. One relative said, "Staff are very good at updating us and they always ask us if we want to be involved in reviews." One person's advocate told us, "They involve and consult with me considerably. There are good lines of communication." This demonstrated people and those important to them were involved in the planning of their care.

We saw information regarding how to make a complaint was clearly displayed in communal areas and was also available in welcome packs. We saw that staff were encouraged at team meetings to remind people who used the service how to make a complaint and to view this as a learning opportunity. People who used the service we spoke with and their relatives knew how to make a complaint and who to approach, as per the registered provider's policy. We saw one complaint had been received since the last inspection and that this had been handled appropriately, with the complainant satisfied with the outcome.

We saw each person had a Hospital Passport in place. A Hospital Passport details people's communicative, medical and mobility requirements should they need to go into hospital.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of inspection. We saw the registered provider had made reasonable attempts to ensure a registered manager was recruited following the departure of the previous registered manager. We saw the current manager's application to register with CQC was underway.

At the inspection of July 2014 we raised concerns about the re-active nature of the management of the service, and that management was perceived only to be available when there was a problem. We found some improvements had been made in this regard. We saw the care manager, who worked at this site and another site, had provided additional cover at Nevilles Court whilst the registered provider was trying to recruit a new manager. One staff member we spoke with told us, "[Care manager] is regularly on hand and is very good." Staff were also complimentary about the interim support they received from the compliance manager, stating, "[Compliance manager] comes in now and again to do unannounced inspections. They keep us right." We saw the compliance manager also undertook these unannounced visits on weekends to ensure staff adhered to policies and that standards of care and the premises were maintained. We saw evidence these inspections were rigorous and led to errors being rectified, such as a review of a care plan not being updated in a timely manner.

We found the leadership of the service still required improvement. When we asked people who used the service about the new manager, who had been in post for two months, they were not aware who the manager was. When we asked the new manager about one person's care needs, they were unaware of their needs and had to be prompted by the care manager. The compliance manager explained that they had not spent long at Nevilles Court, as the other site the manager covered was significantly larger and that they had also had a three-week induction.

We also saw the role of 'team leader' had recently been vacated, meaning the two care staff on duty did not have on site access to a senior member of staff unless the new manager or care manager was on site. We saw the care manager had visited the site regularly and when we spoke with staff one said, "[Care manager] has been here a lot recently and is a big help." Two relatives we spoke with stated they did not feel the turnover in managerial/leader roles had had a detrimental impact on care but one said, "The team leader was great but I understand they don't have a senior now – I think that will be a big miss." When we asked the new manager about the vacant team leader role they were unsure if the role would be filled or not. We found they had not yet gained a sufficient oversight of the service.

Staff confirmed they had found the new manager's appointment a positive one and stated, "The manager is an improvement – they have been here more times than the previous manager and are on the end of the phone if we need anything. Give them their due – they say they'll come if we call and they do." Another member of staff stated, "[Care manager] is really good and has a lot of experience – they are here to provide support." We spoke with the compliance manager who confirmed the role of 'team leader', in addition to the two care staff being on duty, was costed into the plans for the service and gave assurances that this role would be filled.

At the inspection of 17 July 2014 we identified concerns that there were insufficient quality assurance systems in place. During this inspection we found these systems had been improved and were operating effectively. The care manager, compliance manager and other staff undertook a range of regular audits on a monthly basis, including medicines audits, nurse call system audits, daily records, first aid, infection control and care files. We saw these checks had led directly to improvements. For example, one check identified the need to update an emergency evacuation plan, whilst another audit identified the need to record a double signature on a MAR record where hand written entries were recorded. We saw, where issues were identified, corrective actions were put in place. This demonstrated the audits in place had a practical and positive impact on the standard of care people received.

Accidents, incidents, complaints, safeguarding incidents were all logged in a 'Trend analysis' file that was reviewed on a quarterly basis to identify if there were any developing patterns to incidents in the service. We found the sharing of best practice and lessons learnt could be improved. Whilst we saw regular staff supervisions, appraisals and team meetings occurred, meaning staff were able to discuss best practice, the registered provider had not yet ensured the planned 'practice development meetings' were taking place. These were planned as a means of holding regular themed sessions to share best practice and discuss any lessons learned. We saw these meetings had been planned and were due to cover such topics as positive behaviour support and mental health awareness but had yet to take place. This meant the registered provider had not yet embedded continuous service improvement through the ongoing sharing of lessons learned and best practice.

We found staff morale to be high and turnover of staff relatively low. One member of staff told us, "We care as a team," and we found staff we observed to work and communicate well together to meet the needs of people who used the service. This demonstrated a strong team spirit, which in turn ensured people who used the service were cared for by a group of carers who displayed consistently caring behaviours and values.

We asked for a variety of documents and policies to be provided throughout our inspection and found them to be up-to-date and accurate, with policies being recently reviewed. We saw auditing had removed some unnecessary duplication of information in files. We saw appropriate notifications had been made to CQC, for example when a DoLS application had been granted by the local authority and the care manager and compliance manager displayed a good knowledge of what information needed to be shared with CQC and other agencies.

We found staff, the care manager and the compliance manager had successfully delivered the person-centred care described in the statement of purpose and that staff took a great deal of pride in the close caring relationships they had with people who used the service. We found the culture to be inclusive and respectful of the needs and preferences of the people who used the service and that this culture was positively reinforced by care staff, the care manager and the compliance manager. We found the new manager had yet to gain sufficient oversight of the service and the absence of a permanent on-site team leader/senior carer role meant there was a longer term risk of people not receiving the support they required if there was a change of care staff personnel, or if the interim support provided by the care manager was not available.