Potensial Limited

Dale 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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 27 and 28 June 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Dale House on 25 July 2014, at which time the service was compliant with all regulatory standards.

Dale House is a residential home in Dipton, Stanley, County Durham, providing accommodation and personal care for up to 9 people living with learning disabilities. There were 9 people using the service at the time of our inspection.

The service had 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.

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

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 including people's rooms, bathrooms and communal areas were clean. Where one room required refurbishment we saw this was factored into the service development plan for the year.

Staff displayed a good knowledge of safeguarding principles and what they would do should they have any concerns. We saw evidence of concerns being raised promptly and decisive action being taken to keep people safe.

There were effective pre-employment checks of staff 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).

Risk assessments were in place to manage the risks people faced. These were reviewed regularly and staff displayed a good knowledge of how to reduce these risks.

There was prompt and regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Staff were trained in areas specific to meeting people's needs, for example Makaton training, which supports people to use symbols to communicate with others. We also saw staff were trained in areas the provider considered mandatory, such as safeguarding, health and safety, moving and handling and dignity.

Staff were supported through regular supervision and appraisal processes as well as regular team meetings.

We saw people who required specialised diets had their needs met and people had choices at each meal, as well as a range of alternatives.

Group activities including fortnightly outings took place and improvements were planned to ensure people who could not choose to engage in group activities had more one-to-one support.

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. The registered manager displayed a good understanding of capacity 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 vibrant and welcoming. People who used the service, relatives and external stakeholders told us staff were compassionate and we saw numerous friendly and caring interactions by staff.

Person-centred care plans were in place and regular service user forums ensured people's preferences were acted on. We saw regular reviews took place with the involvement of people, their family members and relevant professionals.

The service had built and maintained good community links, pro-actively involving the community in fundraising.

Staff, people who used the service, relatives and an external professional we spoke with had confidence in the registered manager, particularly with regard to their passion and competence in providing high quality care to people who used the service.

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 care plans were in place to help staff reduce these risks.

Pre-employment checks of staff reduced the risk of unsuitable people working with vulnerable adults.

There were safe systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Staff were appropriately trained and their competence regularly assessed.

Is the service effective?

Good

The service was effective.

Staff received training specific to the varied needs of people, for example Makaton training to support communication, as well as a range of training the provider considered mandatory.

Meals were varied and staff consistently met people's nutritional and hydration needs. People who used the service contributed to menu planning and there were a range of alternatives available.

The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives praised staff for their caring and dedication. All relatives and external stakeholders we spoke with were consistent in this regard.

Staff communicated well with people with varying needs and ensured people were supported to make independent decisions.

Care plans were written with the involvement of people who used the service and decisions were taken with the help of advocates where appropriate.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and a keyworker system successfully ensured people's individual preferences were respected.

Staff liaised well with healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

The service had in place a range of activities in place and we saw people were able to engage in hobbies and interests meaningful to them.

Is the service well-led?

Good

The service was well-led.

We found the culture to be open, inclusive and welcoming of feedback and challenges as a means of improving service delivery.

Quality assurance and auditing systems were effective and staff at all levels were accountable for ensuring care was delivered to a high standard.

People who used the service, their relatives, staff and external professionals we spoke with told us the registered manager was approachable and had a good knowledge of people who used the service.

Dale 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.

We visited the service on 27 and 28 June 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking to people and observing people in the communal areas of the home. We spoke with five people who used the service. We spoke with five members of staff: the area manager, the registered manager and three care staff. Following the inspection we spoke with three relatives of people who used the service.

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, IT 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. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work . No concerns were raised regarding the service by these professionals. We spoke with three external healthcare professionals who also raised no concerns about the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and that staff looked after them well. One person said, "Oh yes, I am safe here." Relatives we spoke with were similarly confident in the ability of staff to protect people against the risk of harm. They told us, "There have never been any concerns in terms of safety," and, "It's champion – [Person] has been there for years and there have never been any problems." People who used the service appeared at ease with all members of staff and we observed people who were unable to tell us about their care acting in a trusting fashion with various members of staff throughout our inspection. When we spoke with external professionals none of them raised any concerns about the ability of staff to keep people safe. This demonstrated that people who used the service were protected from potential harm by staff.

The registered manager and all staff we spoke with had been trained to have a practical understanding of safeguarding. They were able to describe sources of risks, types of abuse and what they would do should they have concerns. We found the registered manager encouraged a culture where practice could be challenged and that staff were supported to raise concerns if they had them. We saw this in action, with evidence of one member of staff raising concerns with their manager about a potential risk of abuse to one person who used the service. We saw prompt, decisive action had been taken in line with the service's safeguarding and disciplinary policies and that the person was protected from the risk of harm.

We found there were sufficient staff on duty to meet the needs of people who used the service, with two carers and one manager on shift. We saw there was an on-call system in place should staff need to contact the registered manager (or one of their peers from the wider organisation) with an urgent query. People who used the service, relatives and staff all told us they felt there were sufficient staff to meet people's needs. One staff member told us, "We're well staffed and we're never short – we cover for each other." This meant people using the service were not put at risk due to understaffing.

We saw 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 individual medical records contained their photograph, 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 a lack of detail on people's individual MARs. When we asked staff about how people would indicate they required 'when required' medicines we found they demonstrated a good knowledge of people's individual means of communication. We also saw there was detailed information in each persons' separate care file regarding how they might describe being in pain to staff, using verbal or other prompts and therefore when such medicine might be required. The registered manager agreed to ensure this level of information was added to the MARs file to ensure it was easily accessible to any staff member administering medicine.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a

locked cabinet. We saw room temperatures were regularly recorded to ensure they were within safe limits. Nobody was using controlled drugs at the time of our inspection although the registered manager was able to describe how these would be managed and that this was consistent with the medication policy. This demonstrated people were not put at risk through the unsafe management of medicines.

We reviewed three staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service 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 these checks were planned for renewal every three years. We saw the registered manager had asked for at least two references and had verified these. The registered manager also ensured proof of identity was provided by prospective employees. 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 saw individual risks were managed through a process of initial assessment and continual review. We saw appropriate risk assessments were in place for when people left the service to undertake activities. When we spoke with staff they were aware of the risks people faced and what actions to take, as per people's detailed care plans, to reduce these risks. We found risks were reduced through staff adhering to specific plans but also through the registered manager identifying root causes of risks and addressing these. For example, one person was a risk of tripping and we saw staff encouraging the person to use both hand rails whilst climbing the stairs, as per their care plan. We also saw this person's carpet had been replaced with a laminate flooring to reduce the risk of them tripping. The person told us, "I much prefer it – I'm not steady on my feet and I don't want to trip over." They told us they no longer caught their feet on the flooring. This demonstrated that staff managed risks effectively.

We found all areas of the building, including people's bedrooms and communal areas, to be clean, bright and free from odours. We noted one of the first floor bathrooms was in need of refurbishment, with the window-ledge, shower enclosure and flooring all showing considerable signs of wear, making them difficult to clean. The registered manager acknowledged the room required refurbishment and showed us it had already been incorporated and costed into the service development plan for the year. The room was to be refurbished as a wet room to ensure people's changing mobility needs could be more responsively met in future. People who used the service and their relatives raised no concerns about the cleanliness of the service. One relative commented in a 'Service Feedback Form', "Spotless, no bad odours," whilst one relative told us, "It's always clean and tidy." One relative described a time when they visited and found the person who used the service's room to be, "A mess," but acknowledged this was an isolated incident. This meant people were protected against the risk of infections.

We saw the registered manager, area manager and other staff were all accountable for undertaking regular environmental checks of the building and reporting concerns. We saw Portable Appliance Testing (PAT) had been recently undertaken, whilst the periodic electrical inspection was also in date. We saw emergency systems such as the fire alarm and emergency lighting were tested regularly. We saw fire extinguishers/equipment had been serviced and window restrictors were in place. We saw shower heads had been regularly disinfected and descaled to protect against the risk of water-borne infections such as legionella. We also saw water temperature checks had been undertaken regularly to protect people against the risk of burns. 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 shared with the area manager in a monthly management report that identified any patterns or trends.

With regard to potential emergencies, we saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. 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

People who used the service praised staff, stating, "[Staff member] is the best," and, "They look after me." Relatives we spoke with told us, "There are some really good members of staff – the staff are fantastic," "Staff are always knowledgeable and helpful," and, "Staff are very friendly and always try their best." When we spoke with an external professional they were similarly complimentary about staff focus on meeting people's needs, stating, "They've consistently demonstrated a commitment to improving the lifestyles and opportunities of residents." This meant there was positive feedback from a range of sources indicating that staff had the necessary skills and abilities to meet people's needs.

We saw staff regularly incorporated advice from external professionals into people's care planning and delivery to ensure their needs were met. For example, we saw the registered manager had sought advice and support from a specialist behavioural team when one person's behaviours became particularly anxious. We saw the advice included monitoring these behaviours in a way that would allow staff to identify whether there were any identifiable patterns and whether the support offered to the person at times of distress was always successful.

We saw examples of people receiving care from a range of healthcare professionals and experiencing good quality of life outcomes thanks in part to the prompt and effective liaison with these professionals by the registered manager and other staff. We saw people were supported to access health care services such as GP visits, dentist appointments, optician appointments and chiropody services.

Staff training was well managed. The registered manager used an online system to track when staff were due to renew various training. One member of staff told us, "I've done all kinds of training and they're also helping me to get my NVQ in management." We saw staff were trained in a range of areas the registered provider considered mandatory, such as safeguarding, food hygiene, first aid, infection control and moving and handling. We also saw specific training had been sourced to meet people's needs. For example, staff had undergone Makaton training. Makaton is a method of communication using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. We saw staff were able to understand this person's needs through their understanding of Makaton. We also saw visual reminders to staff of food-related Makoton signs had been put up in the kitchen to ensure staff were reminded of these, and also so that other people who used the service had access to these signs. This demonstrated the registered manager ensured staff were trained appropriately to meet people's needs. We also saw that two people who used the service had epilepsy and that the registered manager was in the process of arranging epilepsy awareness training for staff.

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 medicines competency requirements, cleaning duties and staffing updates were discussed.

With regard to nutrition we saw there was a varied menu with options at every meal. During our inspection we saw refreshments were regularly offered to people and there were healthy snacks available. People were

encouraged and supported to make their own drinks and snacks and one person took particular joy in being able to contribute to cooking and baking. We saw people's choices were sought at monthly residents' meetings and incorporated into menu planning where possible. We saw pictoral menus were in place to help people decide what they would like to eat and observed people making choices during our inspection. Staff took turns preparing food and displayed a good knowledge of people's dietary needs, for example people who required a mashed diet or had diabetes. This knowledge was informed by advice sought from the Speech and Language Therapy (SALT) team. We saw this advice was readily available in the kitchen, alongside allergy information. People who used the service told us they enjoyed the food and confirmed they had a range of choices at each meal.

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 registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises, we found the registered manager had recently installed additional hand rails on the ground floor. We saw they sought and acted on advice from a physiotherapist regarding the height of these rails to ensure the most effective outcome for the person, whose mobility needs had increased. Whilst the building was old, corridors were well lit and clutter-free. We saw there were plans to renovate a bathroom and to update flooring in the living room. We also saw the registered provider had recently employed a new member of staff as a 'Positive Support Facilitator', who would support the registered manager to ensure the premises were continually reviewed to identify means of making the premises as accessible as possible for people who used the service.

Good

Is the service caring?

Our findings

Through speaking to people who used the service and observing interactions between people and staff, we found the service to be caring. One person told us of their keyworker, "They're special," whilst another person told us, "[Registered manager's name] is the best," before hugging the registered manager. When we spoke with relatives they were unanimous in their description of the caring attitudes of staff. One relative said, "I'm in there quite frequently and the level of care is very good," whilst another told us, "We're very happy with the care and everyone gets on well – it's a small service so everyone gets on." This demonstrated that people felt well cared for by staff they had formed genuine bonds with.

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 had consented to their showering care plan, which was extremely detailed and made it clear to staff what tasks they were to help with and what tasks the person wanted to complete themselves. This person told us, "I am at home and looked after and I can do what I like to." Another person had an extremely detailed shaving care plan, which ensured they used an electric shaver but that staff should support the person to make sure they had completed the task.

On arrival we saw people who used the service taking part in the day-to-day upkeep of the home, for example, helping to empty their bin and helping to unpack shopping. One person was pleased to take responsibility for signing for delivery of the shopping. When we spoke with relatives about people's levels of independence, one relative said, "They let [Person] do as much as they can. They feel at home." This meant people were supported to maintain their independence as far as they were able.

Staff had made strong bonds with people who used the service. On one occasion, a person who used the service had to spend time in hospital. We saw the registered manager and staff had arranged a rota to ensure staff members visited the person, outside of working hours, to ensure they maintained the bond they had with members of staff. This demonstrated staff had formed strong, lasting relationships with people they cared for.

We saw staff adjusting their communication style to meet the needs of different people, for example using Makaton to communicate with one person. We also saw staff speaking to one person using short, closed questions so they could clearly understand the options they were being given. This was in line with the person's communication plan, as they struggled when asked open questions. Staff interactions we observed were always patient and respectful. We observed one staff member supporting a person to go to the shop and they regularly asked the person what they would like to get on the outing and what they would choose to do when they returned.

We found the atmosphere and culture of the service to be welcoming, inclusive and relaxed. People who used the service enjoyed showing us around their home and the things they valued. For instance, one person showed us how they had helped to bake cakes that day. Another person who used the service was celebrating their birthday and staff and other people who used the service were preparing a buffet. Another

person showed us their room, which had recently been decorated to their tastes and was personalised with family photographs. They told us, "I am always happy to show people round when they come – I like meeting people."

Relatives we spoke with told us they were always welcomed by staff, that there were no restrictions on visiting hours and that the atmosphere was, "Homely." In 'Service Feedback Forms' that had been completed we saw visiting registered managers from the registered provider's other locations, a family member and a social care professional all responded positively regarding the atmosphere in the home.

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 chosen to have butterfly wallpaper and a range of photographs on their wall.

We found care plans to contain good levels of information regarding people's preferences and wishes and, where people were able to consent to their care and treatment, they had done so. When we spoke with staff they knew about people's individual needs and preferences. The registered manager displayed a good understanding of advocacy. We saw they had ensured an advocate supported a person recently to ensure a decision about dentistry work was in the person's best interests. More generally, the registered manager ensured relatives were involved in decisions relating to people's needs to ensure there was a level of advocacy when making decisions about people's care.

We saw all staff had undertaken end of life training two years previously. The registered manager confirmed nobody using the service was receiving end of life care but that they planned to refresh this training to ensure staff were appropriately skilled should this happen. This demonstrated the registered manager had regard to people's longer terms needs and their right to choose how and where they would like to be supported at the end of their lives.

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.

Good

Is the service responsive?

Our findings

We found care planning and provision to be person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. We found people's individual interests, preferences, as well as their anxieties were taken account of. For example, it became clear when the registered manager was recently unable to attend work that one person who used the service was particularly concerned by their unexpected absence. We saw staff had talked to them about this, understood what was important to them and ensured an information board in the hall area had the picture of staff members due to be on shift on any given day. We saw the person's care plan had been updated to ensure any staff member knew the importance to this person of knowing who was on shift. We also observed staff interacting with this person and reassuring them on occasion about when they were next on shift.

People who used the service told us they could go to the shops when they wanted to and that they enjoyed a range of activities such as going to the hair salon, pedicures, bingo, crafts, dominoes. A group outing was arranged every other Wednesday, the most recent of which had been a picnic in a park in Gateshead. One person told us they had, "Loved it". One person attended a weekly line dancing class and we found links with a local community centre provided people with opportunities to take part in group activities.

People who used the service and their relatives were generally satisfied with the levels of activities available. One relative said, "[Person] goes to the day centre pretty much every day." One relative expressed concerns that some people may lack stimulation where they chose not to be involved in group activities. Another relative suggest people's experience in the home could be improved with access to the internet. We asked the registered manager how they reduced the risk of under-stimulation and they told us they planned to introduce more one-to-one support hours for people, as well as giving lead responsibility for activities co-ordination to one member of staff. This responsibility was currently shared between all staff.

We saw each care plan contained a detail pre-assessment of people's needs and goal-orientated care plans. We saw people had achieved their goals, such as helping to redecorate their room, whilst other goals were in the process of being achieved, such as one person who wanted to take up swimming again. The registered manager was able to show us that, whilst this had not happened yet, it was in the process of being arranged.

Care files were well-ordered and easy to follow for care staff and visiting professionals. Each contained people's photograph and details of each person's keyworker. We found this system had worked well, with staff showing a good knowledge of people's needs and people behaving in trusting, familiar ways with their respective keyworkers. We saw care plans were reviewed regularly. We saw people who used the service and their relatives were involved in the review process, with one relative stating, "I am very much involved."

We saw staff were able to identify when people's needs changed and ensure support was provided by a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. One relative told us, "[Person's] mental health is the best it's been for a long time," whilst another said, "We're lucky [Person] is in Dale House – they make sure [Person] gets access to good care." This demonstrated staff

ensured people's changing needs were met.

Surveys of people who used the service, staff and relatives were used as a means of gathering more information about the service. We looked at the most recent surveys and saw all respondents had ticked 'Excellent' regarding the level of care provided, the support from management and the safety of the service. One person who used the service commented on their survey that the home, "Could do with a smoking shelter." We saw this had also been factored in to the service development plan and, during the inspection, saw the area of land where the smoking shelter was due to be placed was being cleared in preparation. This meant people's views were sought and listened to and, where they suggest changes, these were acted upon where practicable.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas and was also available in service user guides. People 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 complaints were welcomed as a means of identifying areas for potentially improving service delivery. For example, one complaint was received from the relative of a person who used the service regarding a lack of alternative options from those on the menu. The registered manager showed us that, whilst there were always a range of alternatives people could ask for, some people were not able to visualise what they would like as an alternative. To resolve this the registered manager produced a pictoral guide to all the alternative food options that were kept in stock so that, should the person not like what options were on the menu, they could easily visualise what else could be quickly prepared.

With regard to the potential transition to other services, 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.

We saw a document called 'Living Well – My Plan' was not fully completed in two of the three care files we looked at. The registered manager told us this was an additional plan to encourage people to engage with ways of maintaining and improving their health. The registered manager hoped this would complement the care plans already in place and contribute to people feeling more independent and actively involved with their care in future.

Good

Is the service well-led?

Our findings

The registered manager had been in post for two years and had extensive experience of caring for people with learning disabilities, as well as older people. We found them to have a good knowledge of the changing needs of all people who used the service. People who used the service were extremely complimentary about the registered manager and showed affection toward them during our inspection. Relatives and staff were consistent in their praise for the open and inclusive culture the registered manager had created. One relative said, "I am happy to approach them and I have confidence that something will get done if I do approach them." Another said, "[Registered manager's name] is always very approachable and they listen to what we're saying." We also saw a comment in a survey returned by a relative which stated, "Staff are very well led by the manager." One external social care professional told us they had been impressed with the management of the service and confirmed they enjoyed a positive working relationship with Dale House staff, stating, "We have no concerns and have been working very closely with [Dale House staff]." This demonstrated the registered manager had successfully maintained a positive, inclusive culture.

We saw good community links had been made and that the registered manager had pro-actively engaged with the community to ensure better outcomes for people who used the service. For example, when 'residents' forums' suggested there should be developments to outdoor space to provide a decking area with seating, we saw the registered manager had used this to forge positive community links. They engaged the local community in fundraising and, on completion of the decking, invited members of the community back to celebrate the opening of the decking area. We saw other good community links had been made, with numerous people attending a community centre and a local priest visiting the service to give communion.

All staff members we spoke with spoke positively about the levels of support they received from the registered manager and the senior carer, saying, "The senior really supports me well. We get lots of training and there is always someone if we need help." Another staff member said, "The manager is always available. They're great. If they are ever not around then the area manager is there for support."

We spoke with the area manager, who also displayed a good working knowledge of people's individual needs, as well as a good knowledge of staffing, care planning and the service development plan. They confirmed they received a monthly management plan from the registered manager which outlined any concerns they required support with, staffing and training levels, incident or accidents and other information. We saw the area manager took an active role in ensuring people who used the service received good quality care. They completed monthly audits of the registered manager's own quality assurance work and conducted their own 'walk around' inspection of the service. We also saw the registered manager intermittently completed audits at another location the registered provider ran, with the registered manager of that service completing checks at Dale House. This assured an additional level of scrutiny of processes.

The registered manager and other staff undertook a range of more regular audits on a monthly basis, including medicines audits, health and safety, care plans and infection control. We saw these checks had led directly to improvements. For example, one check identified some rusting on the bottom of the

microwave and we saw it had since been replaced. Similarly, one check identified a malfunctioning of the audio on the DVD player, which was then fixed. This demonstrated the audits in place had a practical and positive impact on the standard of care people received.

The registered manager and area manager described a good working relationship with the local authority commissioning team and, when we spoke with the latter, we found this was the case.

We found staff morale to be high and turnover of staff relatively low, however we noted there had been three members of staff leave and be replaced recently. We saw existing members of staff had worked flexibly to cover all the necessary shifts to ensure the service did not need to rely on agency staff. The registered manager acknowledged this team effort by nominating the team for an internal award. This displayed the positive team spirit in action, which in turn ensured people who used the service received a continuity of care rather than receiving care from people new to them in the interim.

The registered manager told us they were in the process of signing up to the Social Care Commitment, although this was yet to take effect. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided, accurate and up to date. We also saw a good degree of organisation of key information in the office, such as guidance regarding how and when to make appropriate notifications to CQC. We saw appropriate notifications had been made to CQC.

The registered manager and area manager had a clear vision for how service improvements could continue to be made and how this would impact on people's quality of care. Planned improvements were based on the feedback of people who used the service and other stakeholders and were clearly set out in the service development plan.

We found the culture to be one that welcomed challenges and suggestions from people who used the service, staff and relatives as a means of improving service delivery. We found the registered manager and registered provider had successfully delivered the person-centred care described in company literature and the Provider Information Return, and that staff took pride in delivering this care.