Precious Homes Limited

Swan Court

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

We commenced our comprehensive inspection of Swan Court on 17 September. We visited the location on 17 September 2018 and contacted people's relatives and other stakeholders following this visit. The inspection was unannounced. The inspection was prompted in part by concerns raised by the local authority (who commission some services for people at Swan Court). We had received concerns indicating that the recommendations of some health professionals were not always followed, and a person had needed personal care on occasions, and this had been delayed. We found this may have happened, albeit infrequently, due to a person not consenting to personal care at times, and staff not being able to provide personal care until they did.

This was the first inspection of the service since they were registered to provide personal care on 2017 and there has been no previous rating for the service.

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

Swan Court was built for purpose, and consists of eight flats that include bedroom, lounge and bathrooms as well as kitchens in some instances. There is also a variety of internal and external communal space people can access if wished. The provider has a café (open to the public) located next door that people living at the home could use.

The service provides personal care to younger adults that have learning disabilities/autistic spectrum disorders or poor mental health combined with the former. On the day we visited the site there was seven people receiving personal care and accommodation.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service did not have a registered manager, although there was an acting manager who has now applied to register with CQC. They were present during our inspection. 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.

Risks to people were clearly identified in risk assessments and we saw staff understood these, and followed them when supporting people. We saw there was sufficient staff available to support people and keep them safe. The provider had made us aware of any allegations of abuse at the service and responded

appropriately to these. Staff could tell us what abuse looked like and how they should respond. We found people's medicines were managed safely. Appropriate checks were carried out on prospective staff before they commence work with people.

People's consent was sought by staff with any restrictions to their liberty agreed with the local authority, with these agreements followed by staff. People were supported by staff on a day to day basis to have maximum choice and control of their and we saw staff supported them in the least restrictive way possible; the policies in the service supported this practice. People were supported by staff that were trained, and the provider had begun building on staff skills and knowledge with further, more in depth training. People could access community healthcare as needed. People were involved and supported to choose and prepare their meals where able. People were given support with their dietary and fluid intake to promote their health.

People were supported by staff who demonstrated they were kind and caring when supporting people. People were consistently treated with dignity and respect. People's independence was promoted within their daily routines. People could express their views and choices regarding their daily living. People could maintain friendships and contact with families, and had support from advocates where needed.

People were involved in drawing up their care plans through use of accessible information that reflected the person's communication needs. We saw care plans reflected people's needs, wishes and preferences, and the views of representatives were considered. People's needs likes, dislikes and personal preferences were understood by staff although based on the views of some health care professionals this has taken longer for people with more complex needs. People had access to leisure opportunities they liked and they could readily access these. People were comfortable in the presence of staff and could express dissatisfaction that staff would respond to. Relatives were confident they could approach the provider with any concerns and that these would be responded to.

The provider recognised with people having moved into Swan Court in a relatively short space of time progress to meet some people's individual aims may not have taken place as quickly as hoped, but staff were confident better progress was now being made. There were some mixed views from stakeholders as to the how effective and well managed people's care was, although we saw staff interaction with people indicated that the provider was learning and improving people's individual experiences and quality of life. There were systems in place for governance of the service so areas in need of improvement were identified and people were better protected from potential risk. People were relaxed with managers and staff. Relatives knew who the managers were and were confident they could approach them. Staff felt well supported and informed by the management team. The provider understood their legal responsibilities and had methods to ensure they were up to date with changes in the law and good practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People's assessments detailed risks to their wellbeing, and these were understood by staff.

People had support from sufficient staff to respond to their needs and keep them safe.

Staff were aware of how to respond to allegations of abuse.

People's medicines were managed safely.

The provider carried out appropriate checks on new staff to ensure they were safe to work with people.

Is the service effective?

Good

The service was effective

People's right to consent was sought by staff and any restrictions on their liberty were agreed with the local authority.

People were supported by staff that were trained, with the provider commencing further training to expand on staff knowledge and skills.

People accessed community healthcare as needed.

People were involved and supported in choosing and preparing their chosen meals where able. People were given support with their dietary and fluid intake to promote their health.

Is the service caring?

Good

The service was caring

People were supported by staff who were kind and caring. People were treated with dignity and respect. People's independence was promoted.

People were supported to express their views and make choices

regarding their daily living.

People were supported to maintain friendships and contact with families, as well as access advocates where needed.

Is the service responsive?

Good

The service was responsive

People's care plans reflected their needs, wishes and preferences, and people, and their representatives were involved in their care planning.

People's needs likes, dislikes and personal preferences were understood and known to staff.

People had access to leisure opportunities they chose and liked.

People could raise complaints and these were responded to by the provider.

Is the service well-led?

Good

The service was well led

As people had moved in recently progress to meet some individual aims for people had not always progressed as quickly as planned, but better progress was now being made as people settled in.

Some stakeholders were not always confident people's care was consistently well managed, other stakeholders and relatives told us it was. We saw staff interaction with people during the inspection showed the provider was learning and improving people's individual experiences and quality of life.

The provider had systems in place for governance of the service so that they could identify where improvement could be made so that people were better protected from potential risk.

People were comfortable with managers and staff and relatives said they were confident they could approach managers. Staff felt well supported by the management team.

The provider understood their legal responsibilities and used systems to keep them up to date with changes in the law.

Swan 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.

The inspection was prompted in part by concerns raised by the Local Authority (who commission some services for people at Swan Court). We had received concerns that recommendations of some health professionals were not always followed, and a person's personal care had been delayed.

We visited Swan Court 17 September 2018 to see the manager and staff and to review care records and policies and procedures. We spoke with people during our visit and contacted relatives following the above visit date.

The inspection was carried out by two inspectors. As well as considering the information of concern we received prior to our inspection, we reviewed other information we held about the service. This included notifications, which tell us about incidents which happened in the service that the provider is required to tell us about. The provider had completed a provider information return (PIR) prior to our inspection; this document that told us how the provider was maintaining and improving the service as well as providing other data. We also contacted other agencies such as commissioners and safeguarding teams. We used this information to help us plan our inspection.

We spoke with four people who used the service, one relative in person and one by phone, the acting manager, peripatetic manager, area manager, a deputy manager, and four support staff. We also received comments from four health care professionals by phone and email post inspection. We reviewed two people's care records, that included their assessment, risk assessments, and care plans. We also looked at three people's medicine administration records [MARs], two people's behaviour management records and seven people's records in respect of any restrictions that were in place. We looked at three staff files. We also looked at other records relating to the management of the service, for example audits and complaints records.

Good

Is the service safe?

Our findings

We received concerns prior to our inspection that people were on occasion not safe at the service. For example, people had not been protected due to their needs not being meet (it was stated appropriate personal care was not given on occasion) and people's occupational needs were not met which had led to behaviours that challenged staff. We discussed these incidents with the acting manager who told us how the incidents had been managed and the outcomes of any safeguarding alerts that had been raised with the local authority. They demonstrated actions had been taken to address any issues arising from identified incidents. They demonstrated learning had taken place and steps had been taken to lessen or remove the risks that had led to any incidents.

We saw people were protected by the provider's use of risk assessments. We saw these assessments covered any identified risks. For example, where people or others were at risk due to behaviours that may challenge staff, the appropriate steps for staff to follow were detailed in behaviour management plans. We spoke with staff who could tell us what these steps were with confidence and we observed other staff follow these steps in practice when people expressed anxiety. We also saw people had risk assessments in respect of any daily activities they undertook, whether in the home or in the community. A relative told us that staff approached their loved one's anxiety appropriately. They said, "They know his triggers, he does not like to be held, this would create a situation, they leave him alone and give him his own space and support if needed".

We heard mixed views from health professionals. One told us in response to difficulties a person was having that, "Swan Court did everything open to them to try and manage the risk and maintain the safety of the individual, other service users, the public and staff team". Another health professional told us, "There was a reactive rather than proactive approach to risk management" although the example used to illustrate this we saw had been addressed at the time of the inspection. They also said there was an, "Emphasis on reducing incidents of challenging behaviour, but this seems to be done to minimise risk rather than positive risk taking". The acting manager told us at the point people moved into the home there had been a focus on the safety of people, as they felt people needed time to settle in, and reach a point where the person was less anxious so they could explore more positive ways of risk management. We saw people's risk assessments now documented examples of positive risk taking.

We saw people we met at the time of our inspection appeared happy and comfortable in the presence of staff and we saw some people were happy to approach staff, for example when they wanted a hug. Relatives we spoke with said they felt their loved ones were safe at Swan Court. One relative told us when they took their loved one out of the home they never expressed any concerns when returning and said the person, "Never said I don't want to go back". We saw people could take risks where they chose in respect of daily activities, which we saw were risk assessed. For example, one person was developing skills in cooking, another did their own laundry and we saw others would use the swings and trampoline in the garden enthusiastically.

We found the provider's safeguarding and whistleblowing policies reflected local procedures and contained relevant contact information, with review of people's records showing any identified concerns were

escalated to the local authority as needed. All the staff we spoke with were aware of what constituted abuse and what steps to take should they have concerns about abuse. The provider told us in their provider information return that, 'Safeguarding and whistle blowing processes are part of every member of staff's supervision', this confirmed by staff we spoke with. A 'whistle-blower' is a person who informs on a person or organization who may be regarded as engaging in an unlawful or immoral activity. A health professional told us about an incident where they had seen what was potential abuse and they said, 'I reported this to their management and advised them to contact safeguarding'. They stated they were told how people had been made safe, and we were informed of the incident with confirmation that a safeguarding alert had been raised with the local authority. Relatives we spoke with told us they were aware of who to contact if they had any concerns as to the safety of their loved ones.

We found systems were in place to safely manage people's medicines in accordance with their wishes. A relative told us, "Many times have seen medicines given, [the person] takes them no problem". We also found medicine administration records (MAR) we reviewed were completed correctly. We spoke with staff and they understood how to administer medicines in a safe way. Staff told us, and we saw they had received competency checks from their managers and recent medicines training as reflected in the provider's training plan. We saw some people were on 'as required' medicines, for example for when they became anxious. We saw there were protocols in place and staff we spoke with understood these.

We saw commissioners had identified what staffing levels were needed for each individual person, this information documented in assessments of people's needs. We saw this number of staff was available for each person as required, with staff allocated to individual people. A relative we spoke with told us the staffing levels allowed, "Swapping staff if [the person] gets anxious with one staff will swap, do go out of their way". Staff also confirmed that there was enough of them available to allow them to respond quickly to people's needs and ensure people's safety.

We found a recruitment and selection process was in place that specified the checks needed to confirm staff member's suitability to work with adults; for example, last employer references, health checks and exploration of their working history. We saw these checks were completed. All staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and help employers to make safer recruitment decisions and prevent unsuitable staff being employed. Staff we spoke with confirmed these checks had been completed before they commenced employment.

Staff we spoke with were aware of how to provide care to maintain good infection control and avoid cross infection in accordance with the policies the provider had in place. Staff told us they had access to personal protective wear, such as gloves and aprons when needed and we saw these were used as and when needed.

Good

Is the service effective?

Our findings

We found assessments of people's needs were in place and relatives we spoke with confirmed people were involved in these assessments. Staff told us how they sought information about people's needs, choices and any reasonable adjustments that may be needed due to any personal characteristics protected by law, for example age, gender, race, sexuality and disability. We heard from a health professional however that they did not think one person's needs were fully assessed on admission and the complexity of the person's needs were not fully explored. They did however tell us that the service had since become more responsive to the person's needs and had begun to follow the health professional's recommendations for support of the person. The assessment and reviews we saw at the time of our inspection did reflect the recommendations of visiting professionals, and staff we spoke with had a good awareness of these. The acting manager told us that they were conscious of the need to engage with professionals and worked with any recommendations made, but would need to consider a person's willingness to engage, which they felt had been difficult for some people whilst they were settling in. A relative told us their loved one had a gradual transition into the service from their previous home and, "Staff went to meet him [at their previous home] and work with them to find out about their preferred routines".

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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found staff promoted people's rights, and consent.The acting manager and staff told us how they involved relatives in the decision-making process, and considered their views. Staff were conscious of the need to ensure people as far as possible made their own decisions as to what they wished to do and how they lived their life. One relative told us their loved one, "Can vocalise what they like" but would give responses to please the person asking. Staff we spoke with were aware of this and when we saw them talking to the person they would try and confirm the person's view to ensure it was their choice. We saw staff with other people and they were consistent in asking people what they wanted to do, and observed their reactions to questions when not verbally responding to ensure they respected their choices. Staff we spoke with understood the principles of the MCA, for example one staff member told us, "You have to assume everyone has capacity to make their own decision with support if not able to. Unwise decisions can be made, you can't assume they can't but you have to act in the person's best interests".

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 saw the provider had applied for DoLS for people living at the service and we checked, and found the conditions of these agreements were complied with. A relative we spoke with told us they were aware of the DoLs in place for their loved one, and agreed with it. A professional we spoke with told us, "I was pleased with how they (the staff) responded to the requirements of the supervisory body (for DoLS)".

From observing staff working with people we gained evidence of staff having appropriate skills and knowledge of people's needs that was indicative of them having received appropriate training. This was despite a professional telling us staff did not always have an adequate knowledge of autism, learning disability and positive behaviour support. The acting manager told us all staff completed an autism course as part of their initial induction, this confirmed by training records. Staff told us they had received this training and other training appropriate to working with people with a learning disability and autism. The acting manager told us six staff so far had completed distance learning on autism and were awaiting their certificates, this confirmed by some staff. Staff had also received training in MAPA (in respect of management of behaviours that challenge) and we saw they demonstrated this when working with one individual. We saw and were told by staff and management about several bespoke workshops with health care professionals, for example community nurses, psychologists and occupational therapists. Relatives we spoke with told us they felt staff were well trained and one told us, "Care is based around [the person's] routine and the staff are good. Staff are definitely well trained and [the person] has the support of staff".

One member of staff said, "I love the training, its good". Other staff told us they were well supported with training from the point they commenced work, this through completing the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of people working in the care sector. We saw the provider had drawn up a monitoring tool for overseeing training provision to staff and to ensure refreshers were completed when needed.

The acting manager and staff told us people collaborated on a menu, where they each made a choice of the main meal of the day once a week. We saw a copy of this menu in the main kitchen area. Staff said if a person did not like the meal of the day they were always offered a different option. One person we spoke with said if they were offered something they did not like they would, "Have something else". We saw people were involved with cooking and when they chose went shopping for food. We saw one person was supported by staff to bake cakes during the inspection, and was actively involved in the preparation and vocally indicated their enjoyment. Another person who told us they enjoyed cooking was to move to another flat in the home (with their agreement) so they would have access to their own kitchen, which with support would allow them to prepare their own meals. Their relative told us, "He has done things in the kitchen downstairs, cooking and likes independence, they [staff] are doing a flat up so he will be able to do more cooking". We saw people's dietary preferences were recognised in their care plans. An example of this was where a person had support with selecting healthier options by staff to maintain a healthy intake of food. Staff we spoke with said they would provide advice when shopping as to healthier options, although said the person would not always choose to follow this advice. The staff member said they had made progress with the person now preparing their own breakfast

We saw people had health action plans in place and these showed that they had regular access to a range of health professional's dependent on their specific needs. A relative told us, "Health care, there are no real issues, [person] sees psychiatrist, psychology, GP etc. – all fine". Staff told us some people were not keen on seeing, for example their GP and they said when needed the GP had tried different approaches, including removing their ID badge so as to appear more informal to the person.

The home consists of several individual self-contained flats linked to numerous communal areas that include a lounge, dining area, sensory room and a large garden. The home was built for purpose and has ample space available and one relative told us their loved one, "Loves the garden and the space". A health professional told us the one person found the large communal spaces a cause of anxiety, with them making a choice to spend more time in their individual flat. We saw steps had been taken to accommodate people's different needs, for example a person showed us their flat that the provider had converted to provide them with more space for their laundry, which they indicated was very important to them. They indicated

satisfaction with their new flat.

Good

Is the service caring?

Our findings

We saw people received care and support from staff that demonstrated they were kind, caring and respectful towards people. We saw numerous occasions where staff were interacting with people throughout the inspection and people were seen to be comfortable with staff. Where there were occasions where a person became anxious we saw staff followed directions in people's care plans and would try and ascertain the person's choices wherever possible. A relative told us, "Staff are really good, have really good relationships [with people]". A health professional told us they had always seen positive interactions between staff and people, although did comment they had seen some occasions where staff had used overly complex language. They did however add that they had seen some 'excellent' examples of staff engaging with people and they spoke about people very respectfully. From our observations on the inspection staff were seen to consistently use appropriate, simple language with people suggesting staff were becoming more skilled with communicating with people. Another health professional told us, 'The staff team have a first-rate attitude to their role. Even when faced with challenging situations, they are continually positive and looking at creative ways to problem solved and engage with individuals'.

People could make their own choices. People told us they could decide when they needed support from staff. For example, a staff member said they were working with a person who became anxious in respect of maintaining their personal hygiene, and concerns had been raised this person had not always received personal care promptly. The member of staff could describe why this may happen, and it was due to the person's anxieties. Where this was the person's choices the staff member said they would not escalate the person's anxieties but look to work towards a point where they would then be comfortable in participating with their personal care. The staff member felt they were making progress and the person was gradually becoming less anxious with the staff supporting them with their personal care, this through use of words and language the person was comfortable with.

We saw the building was designed in a way that allowed people access to their own personal space with self-contained flats that contained bathrooms and in some instances kitchens. Staff we spoke with understood what was important in respect of promoting people's privacy and dignity, this reflected in the way we saw them interact with people. For example, one member of staff said, "When the person is watching TV they want us to come out [of their room]." They said staff needed to be available but they would try and be as unobtrusive as possible, with one of the two staff allocated not present but available if needed. In another instance there was a person who communicated that they did not want a staff member in their flat, and we saw staff stood outside the flat door and would talk to the person to ensure they were able to respond if they needed assistance.

Relatives told us their loved ones could be independent where wished. One relative told us how a person could cook their own meals with support and this made they feel more independent. We also saw staff encourage people to complete tasks independently, for example washing up their utensils after lunch.

We heard from relatives that the provider supported them to maintain their relationship with their loved ones. Relatives told us they could visit when wished, and staff kept in touch with them frequently. Some

people had an advocate and we spoke with one that was supporting a person who told us the service was very accommodating to them as an advocate and the person they supported responded well to all staff. An advocate is a person that would represent the views of the person on their behalf to others.

Good

Is the service responsive?

Our findings

People told us staff were aware of their needs and they received the care and support they wanted. Two people we spoke with showed us their pictorial daily planning information on display in their flats that was used as a tool to help them pick their daily routines and what they wanted to do. We saw staff use pictorial images when speaking with one person, to underline meaning and improve the person's understanding. We saw from observation of staff that they consistently took time to talk with or observe people's responses so they can ascertain their choices and ensure they were involved in what support they received. The manager and staff understood the expectations of the Accessible Information Standards (AIS) and how this should be implemented. Information about people's needs was written in simple language, and in some instances supplemented with pictures.

One relative told us how their loved one was involved and said the staff, "Go through flash cards, he has choices as to what he wants to do, he has a wall chart with the week on with which staff are going to be with him and what he is going to do". The relative said they were aware there was a care plan and they had been involved in an assessment where staff had asked for information on their loved one's preferred routines. Another relative said, "I am happy they understand [the person] and how to deal with him. We are involved with everything. I phone up three to four times a week, go twice a week and very happy with his care plan". Health professionals had a mixed view of how they were involved however with some saying they made suggestions but did not receive any follow up response, with some staff not fully aware of their involvement. Another health professional gave a different view and commented, 'From my experience, I have been communicated with every step of the way. This has come via emails, telephone calls, face to face with staff members and professional meetings'. Two of the professionals were both in agreement that it was more difficult to manage the care for people with more complex needs. We spoke with the acting manager about this and they felt there while there had been some difficulties in the settling in period for some people, due to the change in environment and getting to know staff, they felt staff were now making better progress with people. This was a view that staff we spoke with also confirmed and the acting manager was able to show us evidence of consultation with health professionals in respect of people's progress, or barriers to this.

A health professional confirmed they had engaged with staff in training and gave an example of a member of staff who when working with a person who was anxious about personal care and dressing used singing with the person's name within this to which the person responded, 'Brilliantly' and had suggested videoing this approach as role play for other staff. The manager told us the staff member had completed a step by step guide which was then made available to the wider team working with the person. The staff member also assisted with updating the person's care to reflect the methods and strategies they found to be the most successful; these updates then shared with the wider team within a workshop.

We saw the staff had explored different ways in which they could communicate with people so that they could ascertain their choices, and involve them. This including talking to them in a way that relieved their anxiety, using pictorial communication methods and where appropriate hugs to communicate reassurance. We saw that some people had flashcards on a key ring that could be taken around with the person. A professional told us how staff had adapted communication with one person to ensure his choices were

understood, for example been clear about what they wanted to do 'now' and in the 'future' to reflect their understanding of time. The professional said this approach had been productive in ensuring the person's choices were understood. Staff we spoke with knew people's needs and preferences as detailed in their care records, and we saw from observations of their interactions with people that they followed people's care plans and demonstrated they were aware of how to meet people's needs. Staff told us they were kept up to date with people's changing needs. One member of staff told us, "I can look at the care plans whenever I need to, see what the manager writes, what professionals have said and we have keyworker meetings where the manager will talk with staff". Another member of staff told us, "Care plans are easy to read, for one person one member of staff did a step by step guide with care plans lead by his [the person's] behaviour". We found information in care plans we looked at around how staff should interact with people clear and concise, and reflected what we saw when observing staff with people.

We found staff had a good understanding of people's needs and preferences including those where they needed to consider characteristics protected under the Equality Act 2010, for example people's religion which we saw was explored in people's assessments and care plans with example seen where the staff supported a person to access appropriate diet and equipment to allow them to practice their religion. We saw people's care plans considered all the protected characteristics covered by the Equality Act.

The acting manager told us in information submitted before our inspection they had met with the neighbours to build good relationships, and held open days for the home and community café which was based next door to Swan Court. This café is open to the public, and people living at Swan Court visited the café regularly, giving them an opportunity to integrate with members of the local community. They told us about in-house activities that were available, that we saw people participated in during our inspection. This included a sensory room, trampoline, swings, ball games, rip boxes [boxes of materials a person could tear to relieve anxiety] and cooking. We saw different people enjoyed these activities at different times in the day. One person told us they went to college and said they "Did Yoga at College". Their relative also told us they had done several community activities including, "A rock climbing place" and the person had chosen to go to sea life and the think tank. Another person said they had been to the gym. The manager told us a person had expressed an interest in gardening and we saw poly tunnels had been erected in the back garden to facilitate this. This showed staff supported people to have access to leisure opportunities which they could participate in if wished.

We saw there was a complaints procedure available to people, which was available in written and pictorial format and people we spoke with knew how to make a complaint. One relative told us since their loved one moved into the home, "There have been a few little teething things like laundry but anything I have said I know they will sort out, it's just been niggles. I'm confident I can complain". Another relative told us, "I'm not concerned about anything". Staff we spoke with could tell us how they would pick up on whether a person was unhappy and they would explore this with the person or report to management as needed. We looked at the provider complaints log and saw any complaints were documented and responded to. While the provider had a complaints procedure available in different formats, suitable for people's different communication methods, this was not displayed at the time of the inspection as some people had pulled it off the wall when displayed. Relatives we spoke with said they were aware of the complaints procedure, one telling us there was information in a book they had been given when their loved one moved into the home.

Good

Is the service well-led?

Our findings

There was an acting manager overseeing the service at the time of our inspection, and they have now applied to us to become the registered manager. 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.

One health care professional spoke of some occasions where they had the impression that information about people was not passed onto to staff after meetings with the result some staff were unclear about information. They told us support staff said they were disagreeing about how to approach support for one person around a behaviour and they confirmed inconsistencies in the approach, and were unsure about how managers dealt with these issues. We asked the acting manager about how they addressed these issues and they told us they had adopted various methods to involve health professionals and ensure staff followed a consistent approach. They said this included a Community Nurse and Occupational Therapist working shadow shifts with staff where they worked alongside his keyworker, and staff attending meetings/training with health professionals. The acting manager said they would continue to engage with health professionals so they could recognise if there were shortfalls and how these could be improved. They told us Local Authority commissioners had visited the service prior to our inspection and provided positive feedback, with an email seen confirming this. This reflected the comments we received from other professionals, for example one wrote and told us, 'The service is managed well. The manager and deputy manager are proactive with supporting staff and leading by example'.

One health professional told us staff had said to them they were worried about sharing concerns due to the perceived impact on their job. Staff we spoke with all told us they were well supported and were happy in their work however. One member of staff told us, "If I feel like I need supervision I can have and if there are any issues I can take this up with the manager, I am happy working here and enjoy coming into work". Another staff member said, "The service manager is very hands on and I am really supported, any problems I can go straight to the manager". The acting manager did tell us they would be utilising staff survey forms to check on staff satisfaction in the near future. The staff we spoke with said they felt able to raise any issues with the manager or seniors.

We found the provider had established auditing processes so that they could better monitor, identify trends and better respond to risks to people using the service. This included for example, a working/not working form to highlight specific areas that need to be improved upon, with workshops are held for each person's core staff team, so that staff could raise any ideas or concerns they had, allowing management to put necessary actions in place. We saw there were numerous audits in place, these completed by staff at various levels and senior regional managers, that covered for example, the environment, medicines and spot checks on staff during the day and night. Any outcomes we saw were documented and if actions were needed these were monitored and the responsible member of staff identified. The acting manager told us in information submitted to us prior to our inspection that they had recognised that the quality of care they delivered would improve further by increasing the capacity of management and leadership. They told us they were

investing in a new structure with positions for additional members of management.

We asked people how they could share their views with management. Relatives were positive about how managers kept in touch with them, one telling us, "When I visit I always go around [to managers] and phone daily and they give me a run down, they don't mind". Another relative said, "They are always asking my views" and told us they were updated on a person's involvement with activities though photos of the same. The acting manager told us they had sent out survey forms to get people's, relatives and visiting professional's views on the service which, we saw gave positive feedback, for example one relative said, 'Care workers treat [the person] with respect and dignity. The [person] has trust and confidence in his carers'. We saw people and stakeholders were asked for suggestions as to where to make improvements and where possible the manager/provider had followed up on these, for example a professional told us the provider was, "Very flexible, they moved the person to a new room and worked with the person's relative in response to our comments". The health care professionals that responded to the provider's survey all said they had good communication with the service one stating, 'Professionals are welcomed into staff meetings. Individual goals are set for each person'. Staff told us they were involved in staff meetings and received regular updates from managers.

The manager told us they were working to foster links with other agencies, this included for example, social workers, specialist nurses and behaviour management teams. We were aware from speaking to some professionals that some had the view that there had been some lapses in communication at some points. One heath care professional told us, 'When I have met with team leads and deputies, they have given the impression that they will follow advice. It feels like advice is accepted at the time but not acted on. I do tell staff to contact me if the recommendations are impractical or problematic so that we can rethink how to do them, but they have never contacted me about this'. The acting manager did show us evidence that they had worked with other health professionals proactively and did recognised the need to continue working with other agencies to build strong partnership working.

The acting manager and provider was aware of their legal responsibilities, for example submitting notifications in respect of any incidents to CQC, as we saw had happened. The acting manager was also able to explain what their responsibilities were in respect of their duty of candour, and we found they were honest about having encountered some teething problems when the service first opened with admissions of people with complex needs, getting to know these people whilst they were potentially more unsettled due to just having moved, and establishing a consistent and cohesive staff team.

The law requires the provider to display the rating for the service as detailed in CQC reports and the provider was aware of this requirement. As the service did not have a rating at the time of the inspection it was not possible for them to display it at this time.