National Schizophrenia Fellowship

Derwent Lodge

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

This inspection took place on 3 and 4 May 2016 and was unannounced.

Derwent Lodge is registered to provide nursing and residential care and support for 16 people with mental health needs. At the time of our inspection there were 15 people using the service. The service is a detached, single storey property located within a residential area of Derby. The service provides communal rooms, which include lounges, dining room, activities room, smoking room and kitchen. The bedrooms are single occupancy with an en-suite facility. The service has a garden which can be accessed from the communal rooms.

Derwent Lodge had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's safety and welfare was promoted by staff that had a good understanding of the needs of people using the service. People had a key worker and co key worker who worked with them to develop plans of care which supported them with their recovery programme. People's plans took account of potential risks to people and recorded how risks could be minimised whilst recognising people's rights and choices in how they lived their lives.

Staff had access to an out of hours on-call system where they could seek advice from a manager or a member of the clinical team, to ensure concerns about people's safety and well-being were managed well to promote their safety.

Recruitment procedures were robust and appropriate checks were carried out before people started work. Staff received a comprehensive induction and ongoing training. Staff were further supported through regular supervision and an annual appraisal to ensure they had the knowledge and skills to support people. Staff group supervisions were used to share information as to good practice and used as a learning opportunity to develop staff.

People's rights and independence were fully understood by staff that had developed positive working relationships with people, which enabled them to provide the care and support people needed. People's plans of care focused on their recovery and promotion of their independence across a range of topics, which included management of their own medicine and finances.

People were supported to develop cooking skills and to provide themselves with snacks and drinks. The main meal of the day was prepared and cooked by the chef and served by staff in the dining room. Staff encouraged people to eat their main meal in the dining room as part of people's recovery to socialise.

People's medicines were managed and administered safely following robust risk assessments to promote independence where possible. People's consent had been appropriately obtained and recorded. Both staff and the managerial team understood the principles of the Mental Capacity Act and how they might apply to the people who used the service.

Staff worked in collaboration with people using the service and health and social care professionals to promote people's health. People were encouraged to manage aspects of their own health and to attend appointments independently. People's health care needs were regularly reviewed with the person using the service and a range of health and social care professionals.

Staff's knowledge and understanding of the needs of people had enabled staff to develop working relationships with people, which meant people using the service were confident to receive support from staff. The atmosphere of the service was relaxed and people received the support they needed at a time that was appropriate to them.

People we spoke with told us how they managed aspects of their own lives and told us how staff supported them; they told us how their views were sought as to their individual goals and how they had the opportunity to attend meetings to talk about the service. We found staff to be proactive in motivating people to take part in activities, in some instances these had been identified by people as something they wanted to do. The approach of staff promoted people's independence and confidence.

The provider had an effective system in place to assess and monitor the quality of the service. The views and opinions of people who used the service, staff and key stakeholders were sought, which included meetings, completion of surveys and internal audits.

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 were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing had been assessed and measures were in place to ensure staff supported people safely, whilst promoting people's choices and independence.

People were safe and had their needs met as there were sufficient staff working within the service, who had the appropriate skills and knowledge to support people.

People in some instances were supported to be independent with aspects of their medicine. Staff administered and managed people's medicines safely and had their competency to manage medicine assessed.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the appropriate knowledge and skills and who were encouraged to develop through training. This enabled staff to provide care and support and work collaboratively with people in their recovery.

People's plans and records showed the principles of the Mental Capacity Act were used. People's consent to care and treatment was sought. People were encouraged and supported to make decisions which affected their day to day lives.

People's dietary and nutritional requirements were met. People were encouraged to develop their skills in meal preparation and cooking. Where people required monitoring of their nutritional needs this was overseen and recorded by staff.

Staff understood people's health care needs and worked collaboratively with people using the service and a range of health care professionals to promote, maintain and improve

people's health.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who used the service and the staff employed, which was based on the respect and the promotion of people's privacy and dignity.

People's plans of care detailed the support they needed and the goals' people had set themselves as part of their recovery.

Staff encouraged people to make decisions about their lifestyle choices and understand the impact of their decisions on themselves and others.

Is the service responsive?

Good

The service was responsive.

People received a personalised and tailored service which met their needs and enabled them to work towards greater independence, through the building of people's confidence and development of skills. People's views were sought to ensure the support they received was continually reviewed to reflect any changes.

People were encouraged by staff to share their views, which included their attendance at meetings and involvement in their recovery and the setting of goals.

Is the service well-led?

Good

The service was well-led.

The registered manager and staff had a clear view as to the service they wished to provide which focused on promoting people's rights and choices within an inclusive and empowering environment.

Staff were complimentary about the support they received from the management team and were encouraged to share their views about the service's development.

The provider had a robust governance system which enabled them to assure themselves that the service being provided was of a good quality and review the service provided to bring about improvement.

Derwent Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 4 May 2016 and was unannounced.

The inspection was carried out by one inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to us.

Prior to the inspection we contacted commissioners for health and social care, responsible for funding people that use the service, and health and social care professionals who provided support to people and asked them for their views about the service. We reviewed the information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We spoke with four people who used the service and spent time with others in communal areas and the garden. We spoke with the registered manager, the clinical lead service manager, a nurse and two members of the care staff team referred to within the service as mental health recovery workers. We were present at the daily planning meeting. We looked at the records of four people, which included their plans of care, risk assessments and medicine records. We also looked at the recruitment files of three members of staff, maintenance records of equipment and the building, quality assurance audits and the minutes of meetings.

Good

Is the service safe?

Our findings

Staff were trained in safeguarding (protecting people who use care services from abuse) and knew what to do if they were concerned about the welfare of any of the people who used the service. Staff we spoke with understood their responsibilities in providing support to people to help them make decisions to promote their own safety. People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. We found that the relevant checks had been completed before staff commenced work at Derwent Lodge.

People's care records included assessments where potential risks had been identified and were used to develop plans to promote people's safety. This included where people were at risk of exploitation when accessing the wider community. People's plans which were developed with their involvement detailed how risks to their safety and well-being could be minimised whilst promoting independence and choice. An example being to encourage a person to take their mobile phone with them and ensure there was sufficient credit on the phone so they could contact staff should they need assistance whilst accessing the wider community

People were supported to manage their own finances dependent upon their needs. People where they needed assistance were seen asking staff for their money, staff were quick to respond and encouraged people to sign to say they had received it. Staff followed procedures to record financial transactions where people were not involved, to help safeguard people from exploitation and abuse. In some instances people had appointees to support them with their financial affairs.

People's safety within the home environment was promoted by staff carrying out a safety check in the morning, afternoon and evening. The focus was to ensure there were no hazards identified, such as fire escape routes being blocked and to check that people who had decided to remain within their room and chosen not to interact with others and staff were well.

The external door to Derwent Lodge and rooms within the service, such as the kitchenette were fitted with key coded locks, which could be opened by those who knew the combination. A majority of the people who used the service knew the key codes and had independent access to the service and its amenities. Staff supported others who had been assessed as being at risk should they were access certain areas without support, for example by scolding themselves on a kettle, should they access the kitchen independently.

People's plans identified how people's safety and welfare was to be promoted with regards to their mental health. This included guidance for staff to help them identify when a person's health was deteriorating, such as changes in their behaviour. Where changes were noted records showed staff took the appropriate action, which included liaising with external health care professionals in order that the person's well-being was promoted.

There were systems in place for the maintenance of the building and its equipment and records confirmed this, which meant people resided within a service that was safe and well maintained.

Derwent Lodge employs nursing and care staff to support people. Care staff are on site 24 hours a day with nursing staff being on duty during the day. Nursing staff are contactable out of hours through the services on-call system. The nurse can be contacted by staff when they have a clinical concern or query about someone in their care. Where the on-call service was used this was recorded and along with the reason, so that the provider could monitor the system to ensure it was promoted people's safety. Records showed that contact was made with the on-call nurse system where people using the service had requested medicine from staff, which was prescribed to help them when they had become anxious or distressed. The system was audited and reviewed by the provider and discussed in monthly meetings to ensure that the on-call system was being managed well and people using the service were safe. The on-call system included access to managerial staff where the decision was not clinically based, for example where there were concerns about the environment or staffing.

We found the information recorded within the PIR to be accurate and saw evidence within people's records that the provider works in partnership with local community mental health teams, GP's, the Clinical Commission Group (CCG) and the local authority. We found people's needs were regularly reviewed when people's needs changed, this was managed timely when people's safety and welfare was of concern.

A person told us how they kept their medicine in a locked cabinet within their bedroom. They told us when their medicine was due they collected the key for the cabinet from a member of staff. Once they had taken their medicine they returned the key. Whilst another person told us, "Staff give me my medication."

People were supported to be independent in the management of their medicine as part of their recovery programme. There was an individual plan for each person which had been developed and agreed by them with staff involvement. This was monitored on an on-going basis to ensure that the person's medicine continued to be managed well to promote their safety and health.

We looked at the records of four people, some of which administered their own medicine and some where the medicine was administered and managed by staff. We found that medicine had been stored and administered safely.

The provider had a contract with a pharmacist who supplied people's medicine. The pharmacist provided training to staff on the safe administration, storage and recording of medicines and visited the service to ensure medicine was being managed well. Staff were assessed as to their competency to administer and managed medicine safely.

A policy and procedure was in place for the administration of PRN medication (medication, which is to be taken as and when required). People's plans of care included information about the medicine they were prescribed, which included medicine which can be purchased over the counter such as medicine for pain relief. Where people requested their prescribed PRN medicine, for example to help them with their anxiety, this was discussed with the nurse on duty, when the nurse was not on site that the staff member contacted the nurse on call system to seek clinical guidance and approval for the administration of this medicine. This ensured people's safety through the safe administration of people's medicine.

We found people were knowledgeable about the medicine they took and were involved in decisions about the medicine they were prescribed. People told us that their medicine was regularly reviewed. One person told us, "They're looking to take me off my tablets to help reduce my blood pressure." The person went onto tell us about the PRN medicine they were prescribed, "If I get a bit tensed up they I ask for my PRN."

People's medicine was regularly reviewed by a health care professional to ensure that the medicine people

took was working well.

Good

Is the service effective?

Our findings

A recently recruited member of staff who was at Derwent Lodge on the first day of our inspection spent time with the clinical lead service manager. They spoke with them about their induction as well as providing them with an insight into the service's computer system, which staff accessed for a variety of reasons, which included the registering and undertaking of training. The manager planned their induction with them, which included days to cover specific topics and to review the progress of their induction. Newly recruited staff worked towards gaining the Care Certificate. The Care Certificate is a set of standards for care workers that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

On the second day of our inspection we spoke with a second member of staff who were five days into their employment and asked them for their views as to their induction into the service. They told us, "I have found working with [staff name] to be supportive and positive. They have been organised and I have felt comfortable and confident with them." They told us they had been given an induction booklet on their first day, which covered information about health and safety topics, which included fire systems. They told us they had worked alongside experienced staff and that this had helped them to understand their role. The staff member told us they had familiarised themselves with an overview of each person who used the service and that this had provided them with key information about people.

The staff member had been advised they would support a keyworker, working more closely with three named people. The member of staff through discussion was able to talk in detail about the needs of these people and how they had begun to develop a working relationship with them so that they could provide the appropriate support. The member of staff told us how they had worked with someone who found it difficult to motivate themselves to undertake colouring, by sitting with them and sharing a cup of tea and biscuits. This showed that the induction of staff was effective as they were given the support and guidance they needed to provide support to people.

Training records showed that staff had access to topics related to health and safety along with topics specific to the needs of people using the service, which included training on mental health, such as personality disorders. Staff records showed that staff were supervised by the clinical lead service manager on a regular basis and had an annual appraisal. Appraisals were used as a tool to support and develop staff.

A member of staff told us they were currently undertaking 'leadership management training'. We asked the member of staff what they thought the impact on people using the service would be. They told us the training had already made an impact as the staff member had developed with those using the service, activities which people could take part in. They went onto say the course had also enabled them as 'shift leader' to be more effective in structuring breaks for staff, scheduling appointments and allocating staff to support people to access the wider community. The organisation of daily events had meant staff had more time to support people and reduced the anxiety of stress of those using the service as staff knew what their specific tasks for each day.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found one person had a DoLS authorisation in place which did not have any conditions.

People told us they enjoyed the meals, "The food here is great, there is a good choice." Meetings were used to seek the views of people about the meals provided. One person told us, "If we ask for something to be put on the menu then it is." A second person told us how they cooked for themselves regularly in the smaller kitchen and that they bought ingredients from the local supermarket and prepared and cooked their meal. They told us, "I'm going to cook a prawn curry next."

The smaller kitchen was accessible to people and we saw people making themselves drinks. The kitchen as well as having facilities for making drinks had ingredients to enable people to make themselves a snack. People were encouraged by staff to prepare their own breakfast and tea time meal where this was consistent with people's individual goals, to achieve greater independence as part of their recovery.

The main lunch time meal was prepared and cooked by the chef. Each person is asked what they would like from the menu. The daily menu is displayed on the wall next to the kitchen and the weekly menu on the notice board. People were seen to be encouraged to eat their meal in the dining room to encourage socialisation amongst those using the service. We spoke with the chef who told us part of their role was to ensure that the kitchenette had sufficient supplies to ensure people had independent access to food and drink. They said that at present no one required a specialised diet and that if this was the case they would be advised by staff when people came into the service.

People's records evidence that people's diets were monitored where required, which included monitoring people's weight and recording whether people were eating and drinking sufficiently. People's plans of care identified why people were at risk, for example from weight loss, due to a poor appetite, such as an eating disorder linked to their mental health. Staff liaised with health care professionals, which included mental health services and occupational therapists, to enable people to receive the support they needed.

People told us that they had meetings to discuss both their physical and mental health and records showed that people in some instances were independent in managing these, whilst others received support from staff. A person told us, "The doctor comes round she thinks I'm looking well." The nurse told us that where appointments were related to clinical matters, which included reviews of people's needs, to which a range of health care professionals attended then people were supported by nursing staff to attend.

We spoke with a visiting community psychiatric nurse (CPN), they told us that the staff worked well with them and were pro-active in sharing information through telephone calls and e-mails. They told us that the staff had a good relationship with local GP's and that staff from Derwent Lodge signposted people using the service to appropriate health care professionals, such as occupational therapists where required.

Good

Is the service caring?

Our findings

People spoke positively about the staff and the service. The comments included, "It's nice to have people take care of you. I'm happy to speak to staff as I find it helpful." "It's lovely, very nice and good." And "I'd like to stay here for good, my friends are here and I like being here."

The PIR stated that staff were employed on a basis that reflects the core values of the organisation. We found staff spoke with enthusiasm about the people who used the service and their role in supporting people in their recovery and we saw how staff worked to motivate and encourage people with their day to day lives. Staff spent time with people supporting them with their daily lives, which included accessing services within the wider community.

Throughout the day conversations we heard focused in all instances on people's rights and choices, and how staff could work with people in a positive way to improve people's health. Staff continually shared information with each other so all staff worked consistently. In the meeting held in the morning, which takes place each day, we heard how a person had requested that a named member of staff support them to manage their finances within the wider community as the person had a good rapport with the member of staff, this was actioned.

On the second day of our inspection we saw how staff supported people to minimise distress and bring about changes to people's concerns when a verbal disagreement between three people using the service took place. Staff were quick to come to the lounge and by speaking with people calmly were able to identify what the disagreement was about and took action to listen to what each person said so that the situation was resolved.

People had a key worker and co-keyworker who worked closely with them to develop relationships based on trust to enable people to be confident that staff were working with them in their best interests. People's plans of care were developed and reviewed with them, which included their identified goals. One person told us, "I have a keyworker [staff name] and I have talked about the goals I want to set for myself, they [staff member] help me to stay focused. " Plans of care were in some instances signed by the person or had it recorded they had chosen not to sign.

People's records contained a document referred to as the 'licence agreement'. This agreement signed by the person using the service and the provider set out the agreement between the parties as to the expectations of each other in using the service. This showed that the provider worked with people in recognising and promoting people's rights when making decisions about their care.

We found staff to be knowledgeable about the needs of people, telling us about people's needs and how they supported people and were able to identify where improvements to people's health had taken place. Staff were able to provide examples of how people had been encouraged to take up activities and interests based on information they had gathered from conversations with them. For one person this was going out for walks and for another it was the completion of math puzzles.

People's involvement in their recovery plan impacted on the success of their recovery, in both confidence and independence. Staff from the service were committed to involving people in all aspects of their care. A nurse expressed this by saying. "They're partners in their own care." Then went onto say that they involved people's relatives where possible and with the consent of the person receiving care. We found that someone had identified a goal of reconnecting with relatives by visiting them, the person's plan of care identified how this could be achieved and the role of staff. The plan was regularly reviewed and the level of support by staff, which had resulted in the person now using public transport independently to visit their family.

The PIR stated that staff had a person-centred approach empowering people to be at the heart of the support planning process, setting their own goals and defining their own quality of life. It stated that people's views are sought about the service they receive to find out whether people feel they have been treated with respect. The service recognised that the people they work with have ever changing physical as well as mental and emotional needs and require personal care and support that ensures their dignity is maintained at all times.

The daily planning meeting which we attended discussed a person's request that the medicine that had been prescribed was changed as it was not the brand they were used to and were therefore declining to take it. This was being acted upon by the nurse and showed how people were involved in decisions about their care to ensure their treatment was effective.

People's privacy and dignity was recognised and promoted by staff with a focus on the promotion of people's independence and choices and was recognised in people's plans of care as a key aspect as to the current state of people's mental health. Staff were therefore able to monitor people's health and work with people.

People were seen leaving the service throughout the day, accessing public transport to go about their personal business, often independently without staff support. Staff respected people's decision, for example if they chose not to get up, or leave their room, or declined to eat their meal with staff working as a team to provide encouragement and to respond when people did get up, then asking if they wanted something to eat.

People's bedrooms were recognised as a person's personal space and as such were not entered by staff without the person's permission, unless staff were concerned for a person's safety. People had the option of locking their bedroom doors and holding a key to their room. The bedroom's had an en-suite facility, which meant people could meet their personal care needs without leaving the privacy of their room.

Good

Is the service responsive?

Our findings

On one afternoon of our inspection we spent time with people and staff in the garden. Staff encouraged and supported people to take part in the planting and the care of plants as part of their recovery. In some instances this was linked to individual goals and created an opportunity for people to socialise with others and gain confidence through their achievements. A number of people planted seeds, whilst others watered plants already planted within the recently erected greenhouse. One person earlier in the day told me, "I'm going into the garden this afternoon to water the herbs I am growing." They went onto say they had won the seeds, which they had planted in a raffle. They told us, "I'm growing chives, parsley and basil." Staff spent time with each person and encouraged them to take an active part. For some people their being in the garden was a measure of the person's well-being as people's records identified that an aspect of their mental health was a lack of motivation and the need for staff to create opportunities for people to take interest and to be involved.

A person we spoke with told us how the staff helped them and what it was like to stay at Derwent Lodge. "I like it here, because you can go out when you want. You have your own room. Staff play monopoly with me and I go out to [name of local café] with people I have made friends with here." They went onto say that their key worker had worked with them in identifying goals which they were working towards. We asked them whether their views were listened to, and they told us. "We have resident meetings and talk about activities and other things." When we asked them whether their views were listened to they told us they told us that they were. One example, given was "We spoke about activities and what we'd like to do, so a group of us went to West Midlands Safari Park."

People spoke with us about the goals they had set for themselves with the involvement of staff. One person told us. "My keyworker helped set my goals with me, which are to lose weight and to be better in managing my personal care."

Several people spoke to us about a planned holiday later in the year, one person told us. "I'm looking forward to it; we're going by train and staying in a hotel. I am going out with a member of staff to buy clothes for my holiday."

The service manager and nurse told us how they visited people who had been referred to their service by health and social care professionals to meet with them and others involved in their care. This was to determine whether the service was appropriate to the person and that their needs could be met by the staff. Meetings were used to plan peoples move into Derwent Lodge, to ensure all aspects of a person's support were catered for. This was consistent with information provided within the PIR, which stated that people are encouraged to visit the service to help them make a decision as to whether Derwent Lodge was a place they wished to access as part of their recovery.

The registered manager used a recognised model of support called 'mental health recovery star', which enables staff to support people they work with to understand their recovery and record their progress. The system focuses on specific areas of support, which include living skills, social network, relationships, trust

and hope and work. These topics along with others had been used to develop plans of care with people by discussing their needs and by setting themselves objectives and goals which they could achieve.

The plans of care we looked at provided detailed information as to the support people required and recorded people's views as to how they wished to be supported. The goals people had set themselves included a range of topics such as, accessing the wider community linked to their health, such as swimming, attending routine health appointments and establishing links with relatives and friends. Goals people were working towards included day to day living skills, such as laundry, cooking and cleaning. Specific plans of care were in place to support people with their individual needs linked to their mental health, such as poor appetite, medicine management and addictive behaviours such as smoking.

Where people had addictive behaviours, such as smoking they worked with staff to help them manage this along with the financial implications it had. People had in some instances signed an agreement that staff were to securely store their cigarettes on their behalf, which were available to them when requested. These plans identified the role of staff in talking with people in providing guidance in how to best manage their smoking. During the day we saw people who smoked requesting their cigarettes, on each occasion the staff member gave the person the number of cigarettes as agreed, showing that staff supported people individually as per their agreement.

Plans of care provided information for staff as to how they should interpret changes to people's behaviour as an indicator as to changes in their mental health. Staff we spoke with were aware that people's mental health could change regularly and were able to respond to people's changing needs, by working flexibly with them to provide support and offer encouragement when necessary.

We asked people if they were knew how to raise concerns and whether they were confident to do so. People told us, "No worries there, I get on well with the staff." And "We have the opportunity to talk about things."

People are asked to complete a survey, 'What do you think of us?' This can be completed anonymously. The survey seeks people's views in a range of areas, which include whether staff were mindful of their privacy and dignity, did staff listen to what they say, were they involved in decisions about their care and received the support they needed in achieving their goals. Other questions were linked to the environment and asked whether they would use the service again if necessary. We looked at completed surveys and found in the main people's comments were complimentary, the manager told us that when reviewing completed surveys people's mental health was considered, as this could potentially influence the responses within the survey. We asked the manager how the information was used. They told us that individual comments were discussed with the person where they knew who had completed the survey and where necessary used to review and develop plans of care.

The PIR stated that the service had received three complaints; two being from members of the public raising concerns about noise and a person's behaviour. Whilst the third complaint had been made by a person using the service against a fellow user of the service. The manger told us the complaints had been investigated and outcomes shared with the complainants.

Good

Is the service well-led?

Our findings

People who attended meetings told us that their views were sought and acted upon. We spoke with the manager about meetings and they confirmed they were looking to further develop and formalise meetings to improve the sharing of information to promote people's influence within the service. There was in notice board which was used to share information, which included how to raise concerns and the procedure of the provider in investigating concerns, information on advocacy services and general information about events within the community.

Staff within the service were visible in that we saw they were able spend time with people and were available to talk with them. This in part was made possible by the morning meeting, which outlined key areas of responsibility for each member of staff to ensure the individual needs of people were met as well as any specific tasks which needed to be carried out by staff.

In discussion with the registered manager and the clinical lead service manager they were able to describe the vision of the service and the values that they worked towards. These included involving people who used the service in making decisions about their support. They also told us how the service upheld people's dignity and independence by holding meetings and asking their opinion about the service they provided. People we spoke told they felt involved in their care. This meant that the service promoted a positive and open culture amongst staff and people who used the service.

Staff we spoke with were positive about working at the service and told us how they were supported in their role. Staff told us they had regular individual and group supervisions. These gave staff the opportunity to talk about any practice issues they may have and their training needs as well as an opportunity to talk about how they could improve the service. Minutes showed that staff had discussed the development of activities, which had been actioned and discussed with people. We saw the minutes of the regular staff meetings where the organisational values were discussed and issues that may have arisen about the care and welfare of people who used the service could be raised.

Staff meetings, involving all staff were used to review any changes to people's needs to ensure any changes were accurately noted and responded to. Potential uses of the service were also discussed to ensure that should people access the service, staff would have information about the person. Information about the development of the service including changes to policies and procedures were discussed to ensure staff were up to date and working to up to date guidance.

Staff, following changes to how the service was run, which included the roles of staff, told us how their increased responsibility for people's welfare had meant brought about change. Staff took a greater active role in running the service and planning the day, this meant they had more time to spend with people, encouraging their involvement in the development of plans of care and the setting of goals. Nursing staff told us they had noticed how this had brought about a positive change, as staff focused on all aspects of people's wellbeing, and provided nursing staff with more time to focus on clinical issues and liaise with external health care professionals.

Prior to the inspection we spoke with the local CCG who had funding responsibility for some people who were using the service and a contract with the provider. They told us they had no concerns regarding the service delivery. The service reported any incidents in good time and overall the commissioners felt happy with the service that was being delivered.

We looked at the monitoring systems that the service had in place and saw that a range of audits were carried out regularly and were robust. These provided detailed information on the service such as where improvements had been made and a plan for the future. This shows the provider has taken appropriate steps to monitor the service.

Meetings referred to as 'clinical meetings' took place monthly and involved the clinical service manager and all nursing staff. These were used to discuss any clinical incidents and serious and untoward incidents, so that improvements could be identified. These meetings reviewed the development of the staff role within the service and incorporated reflective practice sessions on different health related topics to develop staff knowledge and development. The meeting recorded any decisions made and action required. Evidence as to how reflective practice sessions benefited people using the service were recorded. An example of this was a member of staff presenting information on how medicine could be used to greater effect if given before eating when prescribed, when used for people with a specific health condition.

The completed PIR provided key information about the service and it showed what the provider had done over the past 12 months and what they intended to do in the next year to make improvements to the service.