The Trustees of the Earley Charity

The Liberty of Earley House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 7 and 8 July 2015 and was unannounced.

This was a comprehensive inspection which included follow-up of progress on the non-compliance identified in the report of the previous inspection on 24 July 2014.

At the previous inspection we identified non-compliance against Regulations 13 (management of medicines), and Regulation 20 (records), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From April 2015, the 2010 Regulations were superseded by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection on 7 and 8 July 2015 we found that the provider was meeting the requirements of the comparable current regulations, 12 (2) (g) (safe care and treatment), 9 (3) (b), (h) & (i), (person centred care) and 17 (2) (c) (good governance).

We found that significant improvements had been made in response to the previous issues identified. However, further improvements were necessary to ensure people's ongoing well-being was maximised.

Summary of findings

Risk assessments were not always used effectively to monitor changes in people's dependency. People's food and fluid intake was not consistently monitored when a potential concern was identified. The registered manager took steps to address this immediately following the inspection. The registered manager had provided written guidance and made other changes to systems but the level and range of medicines errors still presented a potential risk to people's wellbeing.

The frequency of staff training, supervision and appraisal were in need of improvement to ensure staff were effectively supported and trained for their role.

The service provides accommodation and care for up to 35 older people in individual or shared flats or bed-sits. The service does not admit people with a diagnosis of dementia although people living there may become in need of support associated with living with this. A registered manager was in post as required. 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.

The service was meeting the needs of people with relatively low support needs very well. The staff did not all yet have the training or experience to support people as their dependency and needs increased. Appropriate alternative placements had been sought where people's needs had exceeded the support available, although at times this had resulted in additional pressure on staff while a suitable placement was identified.

People enjoyed living within the service and praised the staff as caring and friendly. People told us staff were responsive to their needs and sought external medical advice promptly. People told us they enjoyed the food and were always offered a choice of meals.

People's rights and freedoms were respected by staff and people had a high degree of independence and involvement in their care. People were also consulted and involved in decisions about the operation of the service and the activities and outings provided.

The management team sought people's views about the service regularly. They had addressed issues when they were raised and were committed to the continued development the service. Additional support and monitoring systems were being introduced to enable more effective oversight of the day to day operation of the service. Healthcare support and advice from external specialists had been sought to develop the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was generally safe although there remained a potential risk due to medicines errors which could impact on people's wellbeing. The registered manager had improved storage and monitoring systems and staff refresher training was being provided.

Some risk assessments to provide an indication of potential changes in people's dependency had not always been completed.

Staff understood their role in safeguarding people from abuse or harm and had received training on this. Issues that had arisen had been appropriately investigated.

The service had a rigorous recruitment procedure for new staff and retained the required records.

Is the service effective?

Requires Improvement

The service was not operating as effectively as it could be.

Staff had not yet all received the core training necessary to ensure their awareness of current best practice and to meet increasing needs. The registered manager was taking steps to address this.

Staff had not had performance appraisals and supervision meetings to discuss practice and personal development had not taken place in line with the provider's expectations. The registered manager took steps to address this immediately following this inspection.

People received a varied and appropriate diet, were consulted about menus and given daily choices of food. The advice of dietitians was sought appropriately. However, as some people's needs increased, food and fluid monitoring was not always consistent. The manager had provided training and arranged for additional input from a dietitian.

People's legal rights and freedom were protected. They were enabled and supported to make decisions for themselves about their care.

Is the service caring?

Good

The service was caring. People were very happy with the care and support provided by staff.

People told us their needs were met promptly and that staff were friendly and approachable.

The relationships between people and staff were seen to be positive, with lots of shared humour and warmth. People's dignity and privacy were supported and respected by staff.

Summary of findings

Is the service responsive?

Good

The service was responsive to people's needs and wishes and met their social and emotional needs.

Care planning had been improved and people were regularly involved in planning and reviewing their care. Care plans included more detail about people's life and interests as well as their wishes and preferences.

The service sought the views of people and relatives through annual and monthly surveys and changes had been made in response to issues raised.

People knew how to complain if they needed to. Complaints had been appropriately investigated and resolved.

Is the service well-led?

Good

The service was well led. The manager had prioritised and taken action to address issues which had arisen in the home.

People told us the management team were approachable and responded positively to any issues raised with them.

Systems were in place to enable communication between the staff team and managers and steps were being taken to improve this further.

Appropriate advice had been sought from external healthcare practitioners and others to improve practice.

The Liberty of Earley 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.

This inspection took place on 7 and 8 July 2015 and was unannounced.

The inspection was carried out by one inspector. Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with four staff and the registered manager. We spoke with seven people using the service and one relative.

We observed the interactions and the support provided, including over two mealtimes to help us understand the experience of people in the service. We reviewed the care plans and associated records for four people, including risk assessments and reviews and related this to the care observed. We examined a sample of other records to do with the operation of the service including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for six recently appointed staff.

Requires Improvement

Is the service safe?

Our findings

At our inspection of 24 July 2014 the provider was not meeting the requirements of the then Regulation 13, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service users were not protected against the risk of unsafe use of medicines as the provider had failed to ensure appropriate arrangements for the safe keeping, recording and dispensing of medicines. The provider sent us an action plan in October 2014 describing the actions they were going to take to meet the requirements.

At this inspection on 7 and 8 July 2015 we found that the provider was meeting the requirements of the current regulation and had taken a range of steps to improve the management of medicines which had significantly reduced the risk to people within the service. However, further improvement was needed in terms of the potential risk to people from medicines errors.

The provider had put a new medicines procedure in place. The registered manager had introduced a system of medicines records checks at the point of handover between shifts to safeguard people from the possible impact of medicines errors or omissions. Meetings had been held with senior care staff to reinforce their responsibilities with regard to medicines and discuss the new monitoring procedure. Clear written guidelines had been provided to administering staff. Discussions had also been held with regard to effective checking and recording of 'controlled drugs'. Controlled drugs are medicines with additional specific storage, recording and monitoring requirements. The registered manager had also introduced a system of investigation and reporting on the circumstances around medicines errors. The pharmacist supplying the home's medicines carried out an audit of the service's management systems and records in October 2014. This raised three recommendations about record keeping and one about improving control of stock for 'as required' medicines. We saw some ongoing overstocking of 'as required' medicines and creams. It appeared that re-ordering had sometimes been done automatically rather than based on checks of remaining stock, which could be wasteful and led to large amounts of excess stock which needed to be returned to the pharmacist.

Six of the senior care staff who administered medicines were provided with refresher medicines training in June 2015. One staff member was unable to attend on that occasion but would be provided with the update in the next six months. Senior carer staff had not yet had their medicines competency reassessed following the training but this was planned in the near future.

The medicines error reporting system had identified ten medicines errors/omissions in the 12 months since the last inspection. Disciplinary action had been taken in one case. Some further changes had been made as the result of investigating these incidents. For example 'do not disturb' tabards had been obtained for the staff to use when completing the medicines round and we saw these in use. The medicines cabinet had been relocated from the busy office to new medicines rooms on each floor to reduce distractions and a double signatory system had been introduced. Together these changes helped ensure the risk to people in the home was reduced. The service had promptly sought the advice of the GP in each case and had notified the person and/or their family of the error as appropriate.

The controlled drugs records showed appropriate ongoing checks of the remaining balance in each case. However, records would have been easier to track if the log had been indexed and cross referenced to identify the follow-on page in each case. The binding of the controlled drugs log was coming apart and it required replacement to ensure the ongoing integrity of these records. This was replaced following the inspection and indexed as above.

Almost half of the people managed their own medicines to varying degrees with some being prompted or assisted by staff. Where people managed their own medicines they had their own lockable medicines cupboards in their flat and had chosen where this was sited.

People's ability to manage their medicines had been risk assessed. One person ordered and managed their medicines without involvement from the service. Other people's medicines were ordered by the home and provided to the person, usually a week at a time to manage themselves. Medicines were mostly provided packaged in 'blister packs' with the tablets for each time of day packaged separately. At the end of each week (monthly for one person), the returned packs were checked to see that tablets had been taken before providing the pack for the next week. Medicines records were marked to confirm

Is the service safe?

self-administration and people signed for receipt of these. The care services manager explained that if checks showed someone was no longer managing their medicines effectively, self-administration would be reviewed with them.

People's safety within their flats was supported because the flats had emergency call buttons available in each room. People had also been offered a pendant emergency button to wear around their neck in case they were unable to reach the wall mounted alarms.

People told us they felt safe living in the service. One person said: "Oh yes I feel safe" and another person told us: "All the staff are ok, I feel safe here".

The service had reported safeguarding issues when they had arisen and had responded appropriately in each case. They had consulted and cooperated with outside agencies where appropriate in terms of any resulting investigations.

Staff understood their role in safeguarding people and their actions had demonstrated this. Safeguarding training had either recently been attended or was booked for all staff. Staff knew about the whistle-blowing procedure if they had concerns about the service they felt were not being addressed.

People had some relevant risk assessments in their files, for example where a dietician had recommended their food or fluid intake was monitored. However, risk assessments to provide a baseline indication of their dependency, such as risk of falls, malnutrition and for manual handling, were not always completed. While the majority of people within the service remained quite able, it was acknowledged that dependency levels had risen and some people were now requiring increased support. For example, the service had instigated food/fluid monitoring themselves for some people where staff had expressed some concern. However, there wasn't a malnutrition/dehydration risk assessment in place in every case where this applied. The registered manager agreed to ensure that this was addressed.

People supported by the service generally had low support needs. Most people in the service managed the majority of their needs for themselves with prompting and support as required. Five people required varying degrees of regular personal care support. Staffing levels on shift reflected this. One care staff was on duty for each of the four "wings" of the building supported by a senior carer, a duty shift manager and an activities lead person working across the service. The deputy manager (known as care services manager) and the registered manager also worked extended office hours on site. The deputy manager was also on site alternate weekends and the registered manager was pursuing managerial cover for the remaining weekends. At night people's needs were met by two waking care staff and a senior care staff sleeping-in who was available for advice, emergencies or medicines needs.

Where people's needs had begun to exceed the support levels provided by the service, reviews had taken place to discuss planned moves to suitable alternative services. Two people were in hospital at the time of inspection. The available staff deployment met people's current needs. None of the people we spoke to suggested staffing levels led to any delay in their needs being met. We saw no occasions where people had to wait unduly for staff to respond to their needs.

The registered manager told us the service preferred not to use agency staff but had needed to do so during periods of staff shortage earlier in the year due to staff sickness, retirement and due to providing support for people who had returned from hospital with additional needs. Agency staff usage had been reduced and rotas for the last three months, showed only 8 shifts had included agency staff.

The home was now close to fully staffed but required one more senior and one care staff to provide cover for some people who were reducing their hours. The service had employed 8 relief carers to provide flexible and responsive cover for shortfalls, for example due to leave or sickness.

People were safeguarded by the service's recruitment and selection procedure. Recruitment records showed the service had a robust recruitment procedure in place. Prospective staff completed an application form which included a declaration of any previous criminal record. Records included the required evidence of the process including details of a criminal records check, copies of references and employment history. One person was working only alongside other staff pending the return of their criminal records check. One person had a gap in their recorded employment history which was addressed during the inspection. The registered manager undertook to obtain copies of additional documents for one staff member A copy of their pre-employment health check was located following the inspection and filed appropriately.

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Is the service effective?

Our findings

People were supported by staff who knew their individual needs and preferences well and provided support based on their individual wishes. The service obtained the majority of staff training via courses run by the local authority. At times this had meant delay awaiting a suitable course as limited places were provided to a single provider on each course. The training records showed that updates were particularly required on health and safety, the Mental Capacity Act, food hygiene and infection control. The local authority had recently provided access to a computer-based training system to provide updates to training to enable this to be provided in a timely way while staff awaited face to face courses. The registered manager was aware of the new care certificate training and proposed to start the two most recently appointed staff on the relevant induction and training towards this award.

The registered manager had redefined the staff hierarchy for more efficient lines of responsibility including supervision. The registered manager acknowledged that supervision had fallen behind and that appraisals had not been carried out. She had worked for a period without a deputy manager to support these processes. The provider's target was for supervision to be provided six times per year with an annual performance appraisal. The registered manager set up a new supervision cycle for managers and senior carers as well as systems to monitor that supervisions had taken place, immediately following the inspection. A new format for performance appraisals had also been devised.

All of the people within the service retained varying degrees of capacity to make decisions about their own care. One person who lived at the service previously had been assessed not to have capacity and following reassessment of their needs, had moved to a more appropriate service.

No one was subject to any 'best interests' decisions about their care or treatment at the time of this inspection. Best interest decisions are made under the Mental Capacity act 2005 (MCA). The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Act also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests.

The registered manager was aware that evidence of Power of attorney needed to be seen where this had been given to a relative, but no one was currently in that position. The registered manager told us she would ask for copies of this documentation if this arose.

No one was subject to any restrictions on their freedom which would have required a Deprivation of Liberty Safeguards (DoLS) authorisation. Everyone was free to come and go in and out of the building at will and none required staff support in the community. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. One person's care plan included guidance for staff on managing an aspect of their behaviour. This had been agreed with the person, the care manager and the Community Psychiatric Nurse (CPN) who had provided the behaviour management plan.

People enjoyed well-presented, tasty and varied meals and a choice was provided. People chose from the menus a week at a time but alternatives were available should people change their mind on the day. People's independence was supported and most people required no assistance with eating their meals. Gravy was provided separately where people could pour it themselves so they could decide whether they wanted it. Staff offered to pour it where people might need prompting or assistance. A choice of drinks was offered as was the option of further drinks should people want this. Individual dietary requirements were provided for. Two people required a Coeliac diet and staff checked with people about what they could have before providing items.

One person told us: "The food and choice is very good". People told us that fresh fruit was provided and encouraged. They said they could also take fruit of their choice back to their flat after tea to have with their breakfast. People made their own breakfast in their flats from items they chose, which were provided by staff weekly on request. Another person said: "The food is very good here" and confirmed that an alternative was offered if you didn't want the menu options. Other people confirmed they were very satisfied with the meals. One said the food was well-prepared and added: "I think it's smashing".

One person told us the staff were good at monitoring their health and said: "If you were unwell [staff] called in the GP

Requires Improvement

Is the service effective?

quickly". Another person told us we would have to: "go a long way to look for a better place than here". A relative said of the service: "I love it". One person had chosen the service because they have previously cared for a relative.

People's weight was checked and recorded regularly. Some people were reluctant to do this every time. The service did not have seated scales to support people and help them feel secure while being weighed which may have contributed to their unease.

Some people's food and/or fluid intake was being monitored based on staff having identified a possible issue with their intake. It was evident from referrals to the dietitian that food and fluid intake was being monitored and reviewed but this was not always clear from the records. The food and fluid charts were not always used effectively due to the lack of stated daily targets. Recording was not always thorough regarding intake or quantities throughout the day. The inconsistent record keeping might not always provide the necessary evidence to assist the dietitian to accurately assess the person's support needs. Immediately following the inspection, the registered manager provided a training session for staff on completing food and fluid charts. A new monitoring process was also established to check they were being properly completed. Standardised measures were identified to assist with accurate completion of fluid charts. A training course on nutrition and assessment was booked for staff in September 2015, from a dietitian.

We saw that concerns about skin integrity had been appropriately referred to the district nursing service. The records of their treatment of areas of skin damage were detailed within the district nurse's notes rather than in the care plan. No one had developed pressure sores in the home.

People each had an individual flat or 'bedsit' available to them with its own front door. Accommodation was reasonably spacious and flats consisted of a bedroom, lounge, kitchenette and bathroom with a walk in shower and toilet. A separate adapted bathroom was also available if people preferred a bath. People's support needs at the time of inspection required no additional adaptations to the premises. Equipment such as hoists to assist with transfers or standing had been obtained when required. People had personalised their flats with items of their own furniture, ornaments and photographs.

The building was light, airy, clean and well-maintained. Contractors were applying preservative to exterior woodwork at the time of inspection. The gardens provided level paths, raised beds and an attractive place for people to spend time. One person in particular enjoyed gardening and others enjoyed regular walks around the grounds. Kitchen hygiene was maintained to a high standard and was awarded a five-star rating in January 2015 following a visit by the local authority environmental health inspector.

Various seating areas were provided along corridors for people to rest or interact with the reminiscence items provided. A choice of dining and lounge spaces was available and people could choose where they wished to spend their time. Many people chose to remain in their flats much of the time aside from mealtimes or to take part in activities.

Is the service caring?

Our findings

People were supported by staff who knew their individual needs and preferences well and provided support based on their individual wishes. The service obtained the majority of staff training via courses run by the local authority. At times this had meant delay awaiting a suitable course as limited places were provided to a single provider on each course. The training records showed that updates were particularly required on health and safety, the Mental Capacity Act, food hygiene and infection control. The local authority had recently provided access to a computer-based training system to provide updates to training to enable this to be provided in a timely way while staff awaited face to face courses. The registered manager was aware of the new care certificate training and proposed to start the two most recently appointed staff on the relevant induction and training towards this award.

The registered manager had redefined the staff hierarchy for more efficient lines of responsibility including supervision. The registered manager acknowledged that supervision had fallen behind and that appraisals had not been carried out. She had worked for a period without a deputy manager to support these processes. The provider's target was for supervision to be provided six times per year with an annual performance appraisal. The registered manager set up a new supervision cycle for managers and senior carers as well as systems to monitor that supervisions had taken place, immediately following the inspection. A new format for performance appraisals had also been devised.

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No one was subject to any 'best interests' decisions about their care or treatment at the time of this inspection. Best interest decisions are made under the Mental Capacity act 2005 (MCA). The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Act also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests.

Where people had given 'power of attorney' to relatives, the registered manager was aware of this although copies of the documentation were not held on file to clarify this. The registered manager told us she would ask for copies of this documentation.

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Is the service responsive?

Our findings

At our inspection of 24 July 2014 the provider was not meeting the requirements of the then Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulations 9 (3) (b), (h) & (i), and 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service users were not protected against the risk of unsafe or inappropriate care because the provider had failed to ensure accurate records in respect of each service user were kept.

The provider sent us an action plan in October 2014 describing the actions they were going to take to meet the requirements. The support of the local authority 'in-reach' team had also been sought to improve care planning practice.

At this inspection on 7 and 8 July 2015 we found the provider had taken significant steps including the introduction of a new care planning system and provided staff with some training and written guidance on its use. New policies had been written on nutrition and record keeping. However, as already noted these systems were not always fully or consistently embedded in staff practice.

Care plans contained details about people's history and interests to support individualised care and identified where people were able to manage aspects of their own care. Where people required varying degrees of staff support this was identified. The care plan for one person who was terminally ill included some details of their wishes regarding end-of-life care but the person had declined to discuss their needs fully. In some cases care issues were not effectively cross-referenced between different parts of the care plan record.

The registered manager had introduced monthly reviews of people's care plans and discussion of the care plan for the 'resident of the day' had been introduced to the handover process. This ensured that staff regularly discussed each person and identified any changes in their wellbeing.

People and relatives told us they were involved appropriately in planning and reviewing care. One person said: "I get good support from the staff" and added that they were: "involved in care planning" and were encouraged to manage their own care as much as possible.

A relative was happy that staff had respected a person's wishes to contact them when the person was unwell overnight. One person told us they reviewed their care plan with staff and added: "I sign it each time". People told us staff were quick to respond to their needs and reacted promptly when people became unwell. One person told us they had asked that day to see the nurse and an appointment had been made for them the following day. Another person summed up their care by saying: "My needs are met".

Staff were aware of people's needs including their dietary needs. One staff demonstrated very good awareness of the potential risk to a person who was late coming to lunch when the regular fire alarm test took place. The automatic fire doors began to close as the person was coming through the door and the staff member's quick thinking helped avoid a potential accident.

Three people had begun to experience the effects of dementia, one of whom was in hospital at the time of the inspection. Plans were being made for one person to move to a service which could better meet their dementia-related needs as the service was no longer suitable for their needs.

One person had been diagnosed with heart failure and negotiations had taken place with them to allow night time checks on their wellbeing by staff. A relative also described a situation where staff had responded promptly to deteriorations in one person's health and arranged for admission to hospital during the night. The service provided good support to people when they were in hospital.

The service responded appropriately to incidents or accidents. For example after one person had a fall behind their front door, which prevented access to assist them, the door was re-hung to enable it to open outwards. This was discussed and agreed with the person concerned.

A number of people had asked to have the doors to their flat held open during the day. As these were fire doors, the in house person responsible for health and safety was exploring the option of a suitable device which would do this but also close in the event of the fire alarm sounding. The proposal had been put to the trustees and was agreed and actioned following the inspection.

People had access to an appropriate range of activities, outings and entertainment. Some external entertainers visited the service. We saw one person playing scrabble

Is the service responsive?

and were told that there were usually two others who took part who were unwell that day. People told us about a boat trip on the river the week before which eight people had taken part in and very much enjoyed. The resident's committee operated the service's amenities fund and helped plan its use. A summer picnic was being planned to raise additional funds. One person told us they enjoyed the church services and said that bible study sessions were also available. They had also enjoyed the poetry reading and other outside entertainment.

Other regular activities included keep fit, bingo, whist, quizzes, skittles and hoopla. One person said they would like it if keep fit took place more often. The activities programme also included 'knit and natter' sessions, hairdresser visits, a sherry morning and church services. A computer with internet access was available to people with staff support if required. Some people used it to help remain in contact with family. Relatives were invited to take part in social events in the service.

People had input into the way the home operated via the residents committee and their views were appropriately considered. Many people opted to spend a lot of time in their flats and required limited support. Their choices about this were respected by staff. People were encouraged to have their meals in the dining rooms but could eat in their flat if preferred.

A relative told us staff and management were all approachable. They would approach the registered manager if they had any concerns but had not had cause to do so. One person told us: "The staff sort things out if we are unhappy about something". Another person said they had not complained but if they: "had any issues, they would go to the manager". Others told us they had no complaints about the service or staff. One person described the registered manager as: "very approachable" and described two issues they had raised which had been responded to appropriately.

The service's complaints procedure was displayed prominently and people knew who to speak to if they had a complaint. The complaints log showed that where issues had been raised, appropriate action was taken and they were resolved. For example people had complained about a problem with the front door not responding to the entry control system. The system was checked and the problem was resolved by replacing the front door.

One complaint about a staff member was investigated including discussion with people and was not founded. We saw one concern reported in the incident book which had been addressed appropriately but was not noted in the complaints log. The registered manager agreed to make an entry about it when this was pointed out.

People told us they had been asked their opinions about the service by means of surveys and that they could also attend the residents meetings if they wished, although not everyone did. One person said the managers responded positively when anything was raised.

The most recent survey was carried out in February 2015 by a volunteer not employed by the home. A response had been provided by each person in the service. Overall feedback was very positive with 93% of responses being positive or very positive. All respondents replied that they would recommend the service to others. People made lots of additional positive comments about the service and its staff and a few issues were raised. An action plan was provided to address the issues raised and the findings were fed back to people in a residents meeting.

Changes had been made in response to feedback received from people and relatives. More open discussions were now taking place with people and relatives. Changes in people's needs were better monitored and picked up sooner to enable their need to continue to be met. One person told us that a new laundry staff had been employed in response to complaints about laundry management and described this as: "A change for the better".

People's views had also been obtained through the completion of monthly survey forms completed with people about their experience and whether their needs were being met. The forms noted where issues had been raised and how they had been followed up.

Is the service well-led?

Our findings

Where people had raised concerns about the support they received, appropriate action had been taken. Apologies had been provided and people were told what had been done to address the issue. One person was very happy with the changes made by the registered manager and said: "What the manager has done is positive". They added that the registered manager was approachable and resolved issues quickly when they were brought to her attention. People felt involved and consulted through their involvement in the residents committee and resident's meetings. Another person told us things: "I'm happier with the current management" and added: "It had been an uphill struggle but things were "heading in the right way".

The registered manager had been in post two years and had responded to the shortfalls previously identified in practice and records. When issues were identified during this inspection, action was taken immediately to try to address them. Appropriate action had previously been taken to address issues of individual staff performance. New systems policies and guidance had been set up although these had not always been effectively monitored to ensure they were being adhered to. In some areas monitoring had led to clear actions to address shortfalls.

Communication within the team was maintained through daily handovers and using a communication book to pass on key information. Staff meetings had taken place regularly in 2014 and twice in 2015 to date. The minutes showed that issues had been discussed and staff had been reminded about appropriate practice in some areas. It was evident from the minutes and observations during the inspection that the level of dependency of people supported in the service had increased and staff were still adapting to these changes with the support of the management team. This had led to significant staff turnover which had slowed progress at times but the service was continuing to develop.

The team had been open to external advice and guidance. Guidance had been sought from the local authority 'in-reach' team, the district nursing and community psychiatric teams a dietitian and local GP's.

The registered manager had investigated concerns which were passed on to her by the Care Quality Commission. Events which must be notified to the Commission had been notified as required. Notifications are reports of events that the provider is required by law to inform us about.

The registered manager told us she tried to spend time regularly observing practice and talking informally to people, visitors and staff. She acknowledged that this had not been happening as often as she would wish while other issues and staff shortages were being addressed. Members of the management team had carried out spot checks from time to time. Managers sat in on handover meetings to monitor their effectiveness and keep up to date with changes in people's needs and the issues being experienced by staff. The trustees also carried out visits to monitor the service, most recently in June 2015. Reports showed they spoke to people and staff, observed interactions, checked a range of records and discussed progress with the registered manager. A staff survey had taken place in 2013 and this was due to be repeated in 2015.

The registered manager had established improved recording and monitoring formats to address issues that had arisen where staff recording had not been accurate or consistent. The effectiveness of these systems will be assessed at future inspections.