The David Lewis Centre

Elm Cottage - Middlewich

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

Overall summary

The inspection was unannounced and took place on18 March and 29 May 2015. This location was last inspected in January 2014 when it was found to be compliant with all the regulations which apply to a service of this type.

Elm Cottage is part of the David Lewis Centre which supports adults with complex needs to attain quality of life and to maximise their potential in a safe residential environment. The home is registered to provide accommodation for four people who require support and care with their daily lives. There were four people living there at the time of the inspection.

The home is approximately one mile from the centre of Middlewich. The two-storey domestic type property is close to shops, public transport and other local amenities. The home draws on the rest of the David Lewis Centre for certain support arrangements most notably clinical, social work and administrative services.

There is a registered manager at Elm Cottage. 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.

We found that care was provided in an environment which was as homely as possible. Staff went to

Summary of findings

considerable lengths to make sure that people who lived there experienced it as their own home and undertook the many of the same tasks and made the same choices as other people living in the community.

Staff knew about the need to safeguard people and were provided with the right information they needed to do this. They knew what to do if they had a concern. They were well-trained. There were sufficient staff to meet the needs of the people who lived in the home

The home was well-decorated and maintained and adapted where required. People had their own bedrooms which they could personalise as they wished. As well as community facilities people also had access to the specialist services available at the main David Lewis Site.

As part of the larger David Lewis Centre the home benefitted from being able to use many of the corporate systems which the main provider had developed. This meant that the home was well managed.

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?

Good

The service was safe. Staff knew how to help people to stay safe and what to do if they thought anything was wrong. They had access to good levels of information and risk assessments so that they would know how to respond to people's individual requirements.

There were sufficient staff to meet people's needs and their suitability was checked before they were employed. Medicines were stored and administered safely and the provider made sure that staff knew about the medicines that people were prescribed.

Is the service effective?

Good

The service was effective. Staff were well trained and received a thorough induction when they started in the work. They received regular supervision.

Staff had a good awareness of issues of consent and the requirements of the Mental Capacity Act 2005. Staff knew about Deprivation of Liberty Safeguards and how they applied to people living in the home. People had good access to health care both in the community and from the main David Lewis Centre.

Is the service caring?

Good

The service was caring because we saw that staff supported people in a caring way. People were encouraged to keep in touch with their families and were supported to be as independent as they could be. The home had been adapted where necessary to allow this.

Is the service responsive?

Good

The service was responsive because care planning was person-centred and so the service was planned around individual needs and preferences. People had access to a range of activities including in the community.

Is the service well-led?

Good

The service was well-led because managers, supervisors and team members worked together to provide care that was centred on people's needs. Supervisory staff knew team members well and were to be seen around the care environment working alongside them.

There was a system of checks and audits in place to assure the quality of service provided. Each tier of the management and supervisory hierarchy played a role in making sure this happened.

Elm Cottage - Middlewich

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 was 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 unannounced on the first day and took place 18 March and 29 May 2015. This location was last inspected in February 2014 when it was found to be compliant with all the regulations which apply to a service of this type.

The inspection was undertaken by two adult social care inspectors on the first day during which one inspector visited central departments on the David Lewis Centre site and the other visited the location. Both inspectors returned to complete the inspection on 29 May 2015.

Before the inspection we checked with the local authority safeguarding and commissioning teams and the local branch of Healthwatch for any information they held about the service. We considered this together with any information held by the Care Quality Commission (CQC) such as notifications of important incidents or changes to registration.

During the inspection we talked with one of the people who used the service. People were not always able to communicate verbally with us but expressed themselves in other ways such as by gesture or expression. We spoke with three of their relatives. We talked with four staff as well as the registered manager.

We looked at records including one care file as well as staff files and audit reports. We looked around the building and grounds used by the service.

Good

Is the service safe?

Our findings

One relative told us that they often called in on their relative unannounced and had never had any cause for concern. They told us that they had confidence in the residential manager and would contact her if they needed to in this regard. When we talked with staff they demonstrated a good understanding of safeguarding principles and practices particularly as they might apply to the people who lived at Elm Cottage.

Staff told us that they had received training in safeguarding as part of their induction and we saw from the current annual training plan that safeguarding training also formed part of the annual refresher training programme for supervisory, care, administrative and support staff.

There was a dedicated telephone line reserved for reporting safeguarding matters (including out of hours) which were dealt with by the social work department on the central David Lewis site. Staff could contact this service direct and independently of their line management if they felt they needed to. One member of staff explained how a suspected safeguarding incident had been dealt with and resolved so that the service user was kept safe. Another member of staff showed us a card that was carried by them with the safeguarding telephone number on it and said that the provision of individual email addresses for staff which they could use to make safeguarding referrals was also helpful. Staff told us that they would report any concerns they had and that if they thought notice was not being taken then they would escalate their concerns to another agency. This is known as "whistleblowing".

We visited the social work department. We were shown two records of safeguarding incidents that related specifically to people who were living in the service and we also saw from other records that the system was robust. The social work department maintained regular contacts with the relevant local authority safeguarding teams.

We looked at care records and saw that they contained relevant documentation including comprehensive risk assessments and detailed person centred care plans that reflected the assessed need relating to the person's circumstances and medical requirements. This meant that the service was able to provide care which took account of and where possible minimised risks to the person concerned.

We saw that the records contained detailed information relating to the management of the person's medical condition such as an epilepsy risk management record with a review of seizures and medication plan. Staff told us that they thought that a combination of good training in the management of epilepsy together with extensive assessments allowed them to minimise risk in this area of care.

We saw that where appropriate the in-house speech and language team were involved and any relevant choking risk assessments were undertaken. We saw records that indicated that people were weighed regularly so that any variations could be explained. We saw that the service utilised body maps to record injuries and falls assessments were kept for those people at risk.

Each house had team leaders one of whom was on duty at all times including at night. The remainder of the staffing was made up of care officers covering shifts between 7.30 am and 9.30 pm. There was a total staff group of 13 people and we saw that the usual staffing level was one team leader and three care staff providing an overall 1-2-1 staff ratio to people who used the service.

We saw that this was sufficient to meet the needs of the people who lived in the home. Staff told us they felt that staffing levels were adequate and were confident that they would be reviewed if required. We were told that the service tended not to use bank staff employed across the David Lewis Centre organisation and that staff would work overtime to fill any gaps.

Staff told us that because the house was some distance away from the main David Lewis Centre and was located in the community the usual response in a medical emergency would be to dial 999 and to use local hospital services. Since there was only one person on duty in the home at night this would mean that if a person was admitted to hospital they might have to do so unaccompanied by staff. However the service could supply a patient passport for each person which would provide hospital staff with key information. Otherwise staff told us that they always had the backup of the staff at the main David Lewis Centre site who were available to give advice by telephone including in an emergency.

Given there was only one member of staff on duty at night we asked what arrangements were made in the event anything happened to this member of staff such as if they

Good

Is the service safe?

became ill. We were told that staff from other houses regularly made contact throughout the night to check on each other and that if there were any difficulties then they would alert the David Lewis Centre who would respond.

We saw that staff recruitment was managed centrally by the human resources department at the David Lewis Centre site. We visited the department and asked to see a selection of recruitment records including one which related to the workforce at Elm Cottage. We checked to see if the provider took precautions to make sure that the staff who worked in the home were suitable to do so. We looked at staff files and saw that they included application forms from which the provider could check an applicant's employment history, references which had been checked with the person who supplied it, and records of interview. The provider obtained its own checks from the Disclosure and Barring Service (DBS). These checks help an employer to verify any criminal record and to take this into account when considering employment.

We saw that the registered provider undertook widespread recruitment campaigns but we were told that that the final selection interview was conducted by the registered manager with a residential manager and HR support. The registered provider monitored staff movements regularly and had a clear picture of staff recruitment requirements at any one time. We saw also that some staff were recruited to the community houses from other parts of the David Lewis Centre. This meant that specialist skills and knowledge were retained within the service.

We looked at the arrangements that were in place to make sure that medicines were managed safely. We saw that there was a system for making sure that required medicines were ordered from the local pharmacy in good time so that supplies would not run out. This is particularly important where medicines are required in order to control the incidence of seizures. Staff showed us how medicines were checked on delivery by two members of staff. A medicines administration record (MAR) was then completed by staff who both signed to certify that this had been done accurately.

Because of the importance of medicines being administered correctly we saw that the provider used a specially designed MAR sheet which separately recorded emergency medicines from others such as regular medicines, short course and once only treatments as well as medicines given PRN or "as required". We saw that there were protocols in place so that staff would know how and when to use PRN medicines.

The use of this form of MAR sheet was common across all parts of the David Lewis Centre and this meant that if staff worked in different parts of the service they were always familiar with the same format. We found that staff were well-informed about the medicines which were in use at this location. All staff had received training in the administration of emergency medicines with more senior staff trained in more complex administration. Because of the particular needs of the current group of people who lived in the home the staff group was always adjusted to include one member of staff with more advanced training. The staff could refer to staff such as the centre care nurses at the main David Lewis Centre site if they required additional advice.

We saw that all medicines were stored in a secure room and that the key to this room was kept on the person of a senior member of staff at all times. Within this room each person's medicines were stored separately with a photograph so as to assist with clear identification. We saw that the MAR charts were correctly completed and were up to date.

Appropriate arrangements were in place for medicines to be checked out and back in again when a person left the premises. People who needed to take their medicines carried them in a pouch which had a security lock to prevent unauthorised tampering. If the medicine was used this was recorded and the pouch replenished on return and a new security lock attached. There were no controlled drugs in use at the location at the time of our inspection

Good

Is the service effective?

Our findings

Staff told us that they felt equipped to carry out their role and had access to training relevant to the work. They told us that they felt there was "lots of training" and one picked out a recent day's refresher training in safeguarding and training in medicines as particularly important. We saw that some staff held National Vocational Qualifications (NVQ) in health and social care at various levels. NVQ (and their replacement the Qualifications and Credit Framework) qualifications are competence-based which means that people learn practical, work related tasks designed to help them develop the skills and knowledge to do their job effectively. We looked at training records which showed that training completion levels of better than 95% were being achieved across the locations managed by the registered provider. This meant that staff were trained to do their job and their training was being kept up to date.

When first employed by the provider staff were required to undertake a 17 day induction programme which was made up of a mixture of online and face to face methods. Induction training must be provided by employers within the first twelve weeks of employment to make sure that staff are ready to work with people in a particular setting and that they have the right skills they need to do the job.

Staff confirmed that they had received induction training when they first started employment with the registered provider. Training is provided as one of the central functions located on the David Lewis Centre site. We visited the training department and saw that the programme was made up of the key units of the common induction standards recommended by the employer-led workforce development body for adult social care in England.

Following induction new staff had to complete a six month probation period during which their performance had to be satisfactory. We saw that the probation review included a consideration of whether standards had been met in respect of areas such as safety, safeguarding and person centred care. Subsequently staff undertook refresher training to keep their knowledge and skills up to date. We saw from the training plan that this was extensive and tailored according to each worker's role.

Staff told us that they received regular supervision and we checked supervision records to confirm that this was the case. We saw that these covered reflection on current care practice as well as providing the opportunity for staff to identify training needs. Formal supervision is a meeting that takes place in private with the person's immediate manager to discuss their training needs and any issues of concern. We were told that this takes place at a minimum frequency of six times a year and we saw that records of these were kept in the home in a locked filing cabinet. An electronic system was used to monitor progress on this and to make sure that supervision was taking place as expected. We checked this system and saw that supervision was up to date and that most staff had also had an annual appraisal. The David Lewis Centre has a supervision policy which includes this location. We saw that these arrangements accorded with that policy.

When we spoke with staff we asked them how they made sure that people consented to the care which they were receiving. Staff displayed a good awareness of the need to obtain consent from people and the need to take into account the different levels of mental capacity which people might have and how this might be related to the particular circumstances and context in which they were being asked to give consent. Staff told us that if a person could not verbally consent to something they would use the person's demeanour and reaction to the proposal to gauge whether they agreed or not. They were clear about the importance of obtaining consent.

We saw that the registered provider had used best interest assessments where there was doubt about a person's ability to make a decision for themselves. We saw that this included in relation to medical procedures and for the management of finances.

Because of the different requirements of the people who used the service we saw that staff sometimes used pictorial means to communicate important information to people who used the service. Staff showed good familiarity with which methods would suit each person so that they could match this to their needs.

The Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS) makes provision for people who may not be able to make some decisions or give consent for themselves. Elm Cottage is a care home for these purposes and must observe the requirements of this legislation. When we visited the main David Lewis Centre site we saw that the administration of DoLS applications was managed by the social work department.

Good

Is the service effective?

We visited the department and saw that the provider was following the requirements in the DoLS. We saw that they had submitted applications to the relevant supervisory bodies and maintained systematic records so as to keep track of them once they were authorised. Three of the people living in the home were subject to these arrangements and we checked the relevant paperwork for one and found it to be in order. A clear record had been made of the date of expiry so that the need for its continuation could be reviewed in good time. There was a note that the local authority as supervising body had identified a relevant person's representative for this person. We saw that the social work department also retained links with the local independent advocacy service. When we returned to the home we talked with staff and found that they had a good understanding of these arrangements.

We saw from the annual training plan that training in mental capacity and DoLS was included in induction training for all care staff and was set to be refreshed at two yearly intervals. The provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act and the specific requirements of the DoLS. In each house there were DoLS guides, safeguarding team access details and other safety and procedure protocols visibly displayed in staff areas.

As well as being subject to seizures sometimes, people who lived in the service might behave in an unexpected way that might present a risk to themselves or to those around them. Staff explained to us that they sought to implement positive behaviour management utilising redirection and de-escalation and prompting if people became challenging. One member of staff told us that they thought this was a more effective way of dealing with this behaviour. We saw that the service had a specialist challenging behaviours nurse who developed comprehensive care plans that were reviewed on at least an annual basis or at any point the person's behaviour changed significantly. There was a central reporting system for such incidents meaning that they could be easily reviewed by this specialist and appropriate recommendations made.

We looked at the arrangements for people to eat and drink at the home. There was a well-equipped domestic-style kitchen. We were told that on a Monday the menu was agreed by all the people who lived in the home who then took it in turns to do the shopping usually twice a week. We saw that the home used pictures to help people to choose the meals they would like. We were present during lunchtime and saw that staff assisted people with eating where required. We were told that only one or two of the people who lived in the home were involved in cooking the meal but they all contributed to clearing up afterwards. Staff showed awareness of the need for special diets for some people. We saw that fresh fruit was available.

The people living at Elm Cottage had access to local community health services such as GPs and dentists. People also had access to the full range of in-house health care services provided by the David Lewis Centre site. This provided them with most of the clinical services they required such as doctors, nurses, psychologists, occupational and speech and language therapists, physiotherapists, podiatrist, dentist and the dietician. Staff told us that they felt that this gave people the double advantage of access to community services with the backup of direct access to the very specialist services available at the David Lewis Centre.

Good

Is the service caring?

Our findings

A relative of one of the people living in the home told us "The care is excellent. It's as close to being at home as possible. We feel welcomed by the staff when we visit and they have a nice rapport with (our relative)". They told us that they were kept informed about care plans and invited to attend multi-disciplinary meetings and contribute to them. They felt that their relative was "very happy" at Elm Cottage and felt involved.

During our inspection we heard staff talking with people who used the service in way that was respectful and caring. We asked staff how they made sure that people's privacy and dignity were maintained and both staff told us independently they did this by seeking people's consent, ensuring privacy during personal care by closing doors and curtains for example, by knocking on people's bedroom doors before entering, and by giving people choice. During our inspection we observed that staff treated people in this way. We saw that care staff and the people who lived in the home related to each other in a relaxed and friendly way. Care plans were reviewed at least six-weekly by a multi-disciplinary team.

Staff told us that they used a key worker approach in the home so that each person was allocated a designated member of staff. Staff told us that the duties of a key worker included updating person-centred plans, attending multi-disciplinary team reviews and best interest meetings as well as helping people to choose their clothes and how they would like their bedroom decorated.

People who used the service were able to express their views on their care through service user meetings which were held in the house. We saw the minutes of a recent meeting pinned up on the noticeboard in the dining room of the house. This included pictures in order to address the diverse communication requirements of the people who lived in the home. We also saw one instance of a questionnaire which used a combination of new technology and pictures to record a person's views about their care.

We saw that staff sought to help people to maximise their independence. For example at this location we saw that one person was managing aspects of their own treatment such as monitoring sugar levels and diet. Where people needed help with mobility we saw that suitable aids or equipment were available. An adapted "wet room" bathroom had been created. We saw that people's families were encouraged to be involved in and consulted about their care wherever possible and that people who lived in the home were encouraged and supported to make overnight visits to family where this was possible.

The house has the benefit of a large garden and we saw that people who used the service were using this. The main living area was uncluttered so as to facilitate access and bedrooms were personalised. We asked one person if we could look in their bedroom and saw that they had personalised it as they wanted so as to reflect their own interests. We saw that people were free to use the space provided within the house as they wished. One person chose to return to their room after lunch, other people continued to socialise with the staff in the communal areas.

We saw that because people had a diverse range of communication abilities the service used various means of communicating with people. These included pictorial methods such as to illustrate activities or menus. The "Listen to me" booklet gave people the opportunity to record a large number of preferences including likes and dislikes, important things and important people and how best to communicate with people depending on their mood. People could record their entries in this book either in words or in pictures or both.

Elm Cottage is one of a number of properties provided for small groups of people to live in the community with more independence. Each location is registered separately with the Care Quality Commission. The property is owned by a registered social landlord and rented to the David Lewis Centre. This means that the responsibility for upkeep is shared between the housing provider and the David Lewis Centre. The people who live in the home are therefore not direct tenants of the social landlord.

Although the registered social landlord undertakes redecoration at periodic intervals we were told that the David Lewis Centre will undertake additional redecoration as required and is also responsible for the furniture and fittings. We saw that the property was decorated inside and outside to a very high standard and that furnishings were homely and comfortable. This meant that the house blended in well with the community in which it was located and contributed to the privacy and dignity of the people who lived in it.

Good

Is the service caring?

The provider had made arrangements to implement a recognised care pathway for people who were nearing the end of their life. The aim of this pathway was to ensure all people received high quality end of life care provided that encompassed the philosophy of palliative care. We saw that training in this pathway was included in the provider's training plan.

Good

Is the service responsive?

Our findings

We looked at one set of care plans for a person who used the service and found that this contained the required information to meet the person's needs. We saw that these plans followed a pattern which is standardised across all the services provided by the David Lewis Centre and is called the "common care file". This was a paper based record and care planning system with records held in ring binder folders and neatly stored in a room upstairs. Because the room was locked people could be reassured that their personal information was kept confidential.

We found that the file contained detailed daily logs so that staff could easily find what had been happening with people's care. This helped to provide continuity between different staff. There was a one page profile which is a means of providing staff with key areas of a person such as how they communicate, what they like to eat and drink, how they show if they are happy or sad, and their aspirations for the future. The file contained medical and other information which would be required to support the management of conditions such as epilepsy. We saw that the home included a transition log within its care files which was used to record information whenever a person was joining the service or making a transition between different parts of the David Lewis Centre or out to another service. Another section included risk assessments which had been reviewed. We saw that staff had signed these documents to confirm they had read them and that where possible the person who used the service had signed them too.

We saw that senior staff maintained the records and updated the care plans on a monthly basis, with all other care staff using the daily report records within the notes to document a contemporaneous record of care. This was completed in the morning, afternoon and also at night but additionally whenever something notable needed to be recorded.

We found the care files to be stored correctly, neatly and tidily with contents sections clearly indexed and methodically arranged. The records included a "one page profile" of the person which illustrated a number of key elements such as likes and dislikes, hobbies and "things you need to know about me" plus communication strategies, danger awareness and "things important to me" elements. On this basis the care files would help staff to understand and respond to a person's individual needs. The use of pictorial records helped people who had communication difficulties to take part in and be involved in their own care plans.

The use of person-centred tools such as a "one page profile" meant that the service could be organised around the needs of the person rather than the requirements of the service. As well as encouraging and facilitating involvement this would help any new member of staff to learn a great deal about the person in a short period of time. All care records contained a recent photograph of the person so that any unfamiliar staff could recognise them. All the records we checked contained relevant assessments including comprehensive risk assessments.

We saw that people who lived at the home undertook a number of activities both at home, in the community and by visiting the main David Lewis Centre site. Activities off site included horse riding, cycling, (using the national programme which provides traffic-free routes), hydrotherapy and sensory sessions. Some people went on barge trips, attended football matches and went on excursions such as to a safari park. People undertook shopping journeys into the local community as well as attending a social club and visits to the hydrotherapy pool. We were told that there were some activities which were shared between the people who lived in any of the three houses managed by the same residential manager. These included outings, barbeques and a Halloween party. On both of the days when we visited people who used the service were engaging with staff in activities outside the home such as going for a walk. We also talked with one person who lived in the home who told us that they were employed by the David Lewis Centre and received an income for gardening work.

None of the people we spoke with told us they had any complaints about the home and one person confirmed that they would tell the staff if they were not happy. We saw that there was a complaints policy which was shared across the David Lewis Centre. This was very detailed and outlined the steps to be taken in the event of a complaint being made. The policy identified the importance of communication in the satisfactory resolution of complaints. Relatives told us that they had had some minor complaints in the past but that the registered provider had met with them, apologised and everything had been resolved. We checked the complaints log at this location

Good

Is the service responsive?

but none had been registered. However the home had begun to log items of concern such as where a relative was worried about their family member's welfare and more intensive monitoring of their condition might be required.

Good

Is the service well-led?

Our findings

There is a registered manager at this location. Elm Cottage is one of a seven similar properties which are managed by the same registered manager. The houses are then grouped under two residential managers although one of these posts was vacant at the time of our inspection. The current residential manager was therefore managing all the properties temporarily pending a new appointment.

We saw that the residential manager moved between the three homes under her supervision and it was clear that she had a good knowledge of both the staff team and the people who lived in the home. This provided effective supervision and management and set a leadership style. This in turn meant that during our inspection we saw that staff took steps to make sure that people were involved in making decisions about the care they received. It was clear to us that staff worked as a team and that there was a relaxed and friendly atmosphere which extended across both the staff group and the people who lived in the home.

We saw that the staff and managers took a person-centred approach to providing care. Person-centred approaches help providers and their staff to find out what matters to a person so that they can take account of their choices and preferences. We saw that this was reinforced by the use of paperwork such as the "Listen to me" booklet which was used to help people to think about their life and plan how they were going to go forward.

Elm Cottage is part of the David Lewis Centre which is a registered charity with a board of trustees. We saw that members of this board made regular site visits to all parts of the Centre including this location. Each was made by a different trustee each of whom carried distinct responsibilities. We looked at the most recent of these reports and saw that the visit had been overwhelmingly positive.

It was clear from the reports that we saw that during their visits the trustees took their responsibilities very seriously and wherever possible engaged with both the staff and the people who used the service. This meant that the board received regular information about the running of the service which was independent of the management or staff. No matters of serious concern had been identified in any of these reports. We were given a structure chart which included photographs of senior officers so that people who used the service could identify them.

We saw that the provider also undertook internal inspections. We saw that these were completed quarterly and were carried out by the residential manager. The reports were then sent to the registered manager and seen by the Chief Executive Officer (CEO) and any matters arising were raised with the appropriate manager.

We looked at the most recent of these monthly reports and found that it was comprehensive, detailed and clear on any requirements for corrective action. This confirmed that the registered provider was taking steps to monitor the quality of service provided. We saw that the CEO participated in the internal inspection process which meant that he maintained contact with the service being provided and also provided written team briefings as well as chairing meetings with staff.

We saw that there were other systems of audits or checking in place such as for complaints, staffing levels, fire safety, care plans and finance records. Each person in the management hierarchy had some responsibility for monitoring or auditing service quality. For example we were told that medicines audits were completed by night staff and we saw that team leaders undertook monthly audits and checks of care files. The registered manager completed service reviews and also visited the home as part of a fortnightly rolling programme of visits to all the homes she had responsibility for and also attended some of the multi-disciplinary meetings. This meant that she was able to monitor the quality of service at first hand.

The registered manager told us that she received monthly supervision from the CEO but felt that she could approach him at any other time if necessary and that she felt well-supported. There were also peer meetings between all the registered managers within the David Lewis Centre which she attended.

We saw evidence of forward planning for the service. For example, the registered provider had audited its training arrangements to confirm that they would incorporate all the standards for the forthcoming care certificate which is about to be introduced. The care certificate sets out explicitly the learning outcomes, competences and

Good

Is the service well-led?

standards of care that will be expected in the health and social care sectors and will be replace both the common induction standards and the national minimum training standards.

Registered locations such as Elm Cottage are required to notify the Care Quality Commission (CQC) of certain events. We checked our records and were satisfied that appropriate notifications were being made.