Heathcotes Care Limited

Heathcotes (Wakefield)

Inspection report

Belle Vue Road
Wakefield
West Yorkshire
WF1 5NF

Tel: 01924249175
Website: www.heathcotes.net

Date of inspection visit:
05 April 2018
09 April 2018

Date of publication:
22 May 2018

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

Our unannounced inspection began on 5 April 2018. We told the provider we would return on 9 April 2018 to conclude the inspection. At our last inspection in July 2016 we rated the service as 'good' in all key questions. At this inspection we found the provider was still rated 'good'.

Heathcotes (Wakefield) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides residential care for up to 20 adults with learning disabilities and complex needs, and is located in a quiet area close to the centre of Wakefield. The service is split into two houses and a building containing three flats. These buildings are within shared grounds. There were 19 people using the service when we inspected.

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

There were two registered managers in post when we inspected. 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.

There was an excellent, person-centred culture in the service, driven by a committed management team that led by example and supported their staff at all times. Staff were passionate about providing excellent care and support that was tailored to and respected each person's individual needs and preferences. People's care plans were detailed, person-centred and the provider ensured key information was available for people in formats accessible to them.

Staff were recruited safely, well trained and told us they were proud of the work they did. Staff were deployed in sufficient numbers to provide safe support when people needed it, and we saw staff managed challenging behaviours confidently and effectively. There was a low level of use of 'as and when' medicines in the management of behaviours that challenge. Staff training and practice meant people were safeguarded from potential abuse.

There were good controls in place to ensure the safe ordering, checking, storage and recording of people's medicines. We saw records were fully completed with no gaps, and saw staff had a detailed handover of medicines at each shift change to ensure any issues were identified in a timely way.

People lived in a well maintained home and were encouraged to help in keeping it clean. The home had a very relaxed atmosphere, which we observed people were comfortable in. Staff and people who used the

service clearly knew each other well and we observed appropriate banter which people enjoyed.

People were able to maintain and develop activities they enjoyed and encouraged to increase their independence whenever they were able. This included accessing local amenities and experiences of working in environments meaningful to the individual. People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were clear processes in place to ensure concerns and complaints from people or their relatives were investigated and actioned as necessary, with people being updated as to the outcome. Some concerns which people expressed indirectly were addressed through changes to care plans and other routines, meaning the service was responsive to feedback received in a number of ways.

The provider had mechanisms in place to ensure people who used the service, staff and other people such as commissioners, social care professionals and families could provide feedback which helped drive improvements in the service. People were asked for feedback and we saw action was taken as a result. Staff told us their suggestions were welcomed and respected. Where people may have had concerns about the service or wished to make a formal complaint we saw there were processes in place which ensured concerns were addressed and the quality of the service improved.

The management team were highly committed to making continual improvements to the service, and had very effective systems in place to monitor quality and take action when needed. There was a very person centred culture in the service, and we found everyone who worked at Heathcotes (Wakefield) was committed to delivering a high standard of care and life experience for people. We saw examples of good partnership working with other agencies and professionals involved in people's care, and evidence of good equality and diversity training and practices in place.

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 were recruited safely and deployed in sufficient numbers to meet people's support and care needs.

Risks associated with people's care were well documented, and staff had access to detailed guidance to show how these risks could be minimised. Safeguarding practices in the home were safe.

Staff were well trained in the administration and management of medicines. Controls were in place to ensure medicines practices were safe.

Is the service effective?

Good

The service was effective.

People's capacity to make decisions was well assessed and managed, and the service was meeting its obligations under the Mental Capacity Act 2005 (MCA). We saw people were offered choice and their preferences were understood and met.

Staff had a thorough induction including completion of the care certificate, and access to ongoing support and training.

People had good support to access other health and social care professionals, and we saw healthier eating was promoted in the service.

Is the service caring?

Good

The service was caring.

People and staff knew each other well, and we observed a very relaxed atmosphere throughout the home.

People had complex needs which meant they were not always able to contribute directly to decisions about their care, however staff displayed skill in understanding people's needs and preferences and were empowered to suggest changes and

improvements for people's care plans.

People received good support with their personal care, which followed their preferences and encouraged their independence whenever possible.

Is the service responsive?

Good

The service was responsive.

Everyone that worked in the service was passionate about delivering person-centred care that always reflected and respected people's needs, preferences and potential. We saw any concerns or complaints were robustly addressed.

Care was responsive to changes in people's needs. There were systems and practices in place to enable concerns and complaints well.

There was a good approach to ensuring equality and diversity principles were embedded in the service. There was a good range of accessible information and communication in use in the service.

Is the service well-led?

Good

The service was well led.

There was strong, effective and inclusive leadership at all levels. Staff were proud of the quality of the care and support people received.

The quality of the service was constantly monitored, and we saw people and staff were encouraged to give feedback which influenced decisions made about service delivery.

The service created opportunities to work in partnership with other bodies involved in people's care to ensure people were supported to have the best possible outcomes.

Heathcotes (Wakefield)

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

Our comprehensive inspection took place on 5 and 9 April 2018. On 5 April our visit was unannounced, however we told the provider we would return on 9 April in order to complete the inspection. The inspection team consisted of one adult social care inspector and, on the first day, an expert by experience with a background in supporting people to use this type of service.

Before the inspection we reviewed all the information we held about the service, including past inspection reports and notifications sent to us by the provider. As a part of the inspection activity we also contacted people who commissioned services, safeguarding teams, the fire and rescue service and Healthwatch, a consumer champion which gathers information about the experiences of people using social care services in England.

When planning the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spent time looking around the home, visiting all communal areas and some people's private rooms with their consent. We spoke with 5 people who used the service and made extended observations of daily life in the home. We also spoke with the two registered managers, team seniors and five other members of the staff team. We reviewed four people's care records in detail, including their medicines administration records and stocks of medicines. We also reviewed some care documents and medicines stocks for three other people. We also looked at other documents including those relating to the recruitment, training and supervision of staff, maintenance and servicing of the premises, minutes of meetings and records relating to quality monitoring and improvement.

Good

Is the service safe?

Our findings

People's care plans contained detailed and well organised assessments of risks associated with their daily lives and care needs, with very clear guidance for staff to follow in order to minimise risk as much as possible.

Staff were recruited safely, with appropriate background checks in place. These included references from previous employers, checks on identity and information received from the Disclosure and Barring Service (DBS). The DBS is an organisation which holds records of people who may be barred from working in a social care setting. Potential new staff spent time with people who used the service as part of their interview, and people were also able to participate in of the interview process if they wished, and were free to ask their own questions.

Staff were present in sufficient numbers to ensure people were safe and well cared for, and we saw there were enough staff on duty to enable people to undertake both planned and unplanned activities as they wished. People who needed the support of more than one member of staff had this at all times.

Staff we spoke with were able to describe their responsibilities for safeguarding people, including knowledge of the kinds of abuse people may be at risk from and how and when to report this. Staff told us they were confident the management team would respond appropriately to any concerns they raised. We looked at records which showed any incidents were thoroughly investigated and 'de-briefed' with staff to ensure any lessons learnt could be built into future decisions about care for people. This meant the provider was actively looking for ways to reduce the likelihood of incidents being repeated. Records showed the provider was reporting concerns to bodies such as the local authority safeguarding team and the CQC as required.

Although the service provides care and support to a complex and challenging group of people, there was a shared desire to set meaningful and achievable goals, and a willingness to take positive risks to enable people to achieve these goals. Risk assessments for activities and daily living contained evidence the service explored positive benefits for people's self-esteem, sense of belonging and independence which could be achieved by taking well managed risks. For example, we saw one person had demonstrated and maintained high level of understanding of why they took medicines and how these were managed safely, and a discussion had taken place about whether the person's sense of responsibility and independence could be enhanced by administering their own medicines. The area manager told us they were waiting for a secure cabinet to be fitted into the person's room and then the person would begin a trial of managing their own medicines.

All medicines were stored and administered safely, and records relating to this part of people's care were detailed and well maintained. Key staff were regularly trained and observed in safe medicines administration practice to ensure their training remained effective. Where people had 'as and when' (PRN) medicines, for example for pain or to help manage people's agitation and distress there were clear protocols in place to show when and how these could be given. Medicines care plans contained very detailed

information about ways in which behaviours that challenge could be de-escalated by staff without the need for PRN, which showed the service learnt from each incident.

There were detailed checks in place to ensure that medicines administration records (MARs) and stocks of boxed medicines were correct at each shift handover. MARs we looked at included photographs of people to aid with correct administration, information about any allergies and clear instructions as to the timing, dosage, reason for and potential side effects of all medicines. Where medicines such as creams or pain control patches had to be applied to people's skin we saw there were body maps in place to show where these should go. We checked stocks of boxed medicines for four people and found these matched the records.

Some medicines contain drugs that require additional secure storage and record keeping. These are also known as 'controlled drugs'. We found these were securely stored, and records were well maintained with double signatures where required. We checked the controlled drugs stocks for two people and found these matched the records.

People lived in a very clean, well maintained environment and were supported and encouraged to help with routine cleaning tasks if they wished. We saw records which showed routine servicing of equipment was up to date.

Good

Is the service effective?

Our findings

People who used the service gave us some feedback related to the effectiveness of the service. Comments included, "I have been to the Doctors for my ear infection and have drops for my ears .I am waiting for my hearing aids," "I can go in the kitchen with support to make drinks and wash up and I can get my own breakfast. At our meetings we talk about the menu and choose healthy options, we have lots of choice and healthy food like salads," and "I can go in the kitchen by myself as I have the door code and I can get a drink. I make my breakfast and the staff make lunch and evening meals."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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.

Care plans contained very detailed assessments of people's ability to understand and consent to a large number of aspects of their care and daily lives. There was clear recording of best interests decisions made on people's behalf when they lacked capacity, and we saw these decisions involved key staff, family members, advocates and other health or social care professionals as appropriate. During the inspection we observed staff supporting people to make decisions by offering choices, for example for food or activities. People's preferred choices were well documented in their care plans, for example we saw detailed descriptions of how people liked to dress, how they enjoyed spending their time and when they liked to get up and go to bed.

People's care plans contained an assessment of their need for a DoLS, and we saw these were applied for as required. The registered manager maintained an overview of DoLS which enabled them to submit timely applications for renewals of these in advance of the expiry dates. Some DoLS had been authorised with conditions, meaning the provider had to take specified actions for the authorisation to remain valid. Our review of care documentation showed the service was meeting these conditions.

Staff received a thorough induction, and we saw all staff completed the Care Certificate during their six month probationary period .There was regular observation and feedback during the induction and probationary period to ensure training had been effective, staff felt supported and people were receiving the quality of care they needed. Ongoing training and support was in place and up to date. Staff had regular, meaningful supervision meetings, and staff we spoke with told us these were useful meetings which enable

them to discuss any challenges, successes or training needs they had identified.

People were able to discuss what they wished to eat each week with their key worker, and we saw a pictorial display about healthier eating in the dining rooms. Staff told us they discussed healthier eating with people but respected decisions they made about what they wanted to eat. Staff supported people to understand make appropriate choices about dietary needs, such as those for people with diabetes.

We saw evidence people were supported to access a range of health and social care professionals such as GPs, neurologists, dentists and chiropodists, and care plans contained a 'health passport' which could be given to health professionals to assist them in providing effective care. The health passport contained key information about the person's support needs, communication, preferences and any relevant cultural or spiritual details. This was written in an accessible format. We saw advice received from health professionals was included with people's care plans, and guidance was adapted to ensure this advice was followed.

People had been supported to personalise their rooms to their taste, and had access to their own possessions. We saw how one person had been supported to choose furnishings and paint for their room, and was planning to decorate it themselves with support from their key workers.

Good

Is the service caring?

Our findings

People who were able to give feedback about staff said they were caring and supportive. Comments included, "I like living here and I like my key worker," "Some staff make me smile and they try to make me laugh when am feeling unhappy," "I like everybody, I love living here " and "I am happy with most of the staff. Some are good and some are really friendly. I can talk to my key worker."

Staff told us there were allocated as key workers to people who responded to them well, as this was a good basis for providing support. Two key workers were allocated to each person in order to maintain continuity, for example when staff took annual leave.

During the inspection we saw people lived in a very relaxed, homely atmosphere and were free to spend time in communal areas, in the community or in their own rooms as they wished. Staff were kind and compassionate in their interactions, and spoke about people with respect and fondness when we asked about care and support they provided. We saw people referred to staff by name, and showed they knew them well. We observed a good level of appropriate banter, which people were seen to enjoy. Where people experienced behaviours that challenged themselves or others we saw staff were discreet, supportive and able to use their knowledge of people to quickly de-escalate any tension.

People we spoke with did not indicate they were concerned about their care plans or prevented from contributing to them. Due to their complex needs, many people who used the service were not able to contribute directly to decisions about their care, however staff told us they knew people well and felt empowered to discuss any changes in people's needs, preferences or routines with senior staff. They told us their observations were valued and changes were made to care plans and guidance for staff as needed. Information in care plans was available in alternative formats, for example in a pictorial format to support people to understand how their care and support was planned for if they wished to do so. There was a good level of information about people's backgrounds, preferences, interests and important friendships and relationships in care plans.

There was clear documentation in place to show how people preferred to receive personal care, including detailed guidance about enabling people to maintain their independence in this area as much as possible. Where staff gave direct assistance to people, we saw this was done to prevent other risks. For example, in one care plan we saw guidance for staff to brush the person's teeth for them in order to minimise the risk of a deterioration in dental health. The care plan showed the person was unable to perform this area of personal care for themselves.

Good

Is the service responsive?

Our findings

Enhancing people's quality of life was at the heart of the culture and sense of purpose at Heathcotes (Wakefield). Staff spoke about their commitment to their work with passion and pride, and told us about how they worked to understand, advocate for and enhance the lives of people who used the service. They were able to describe people's needs, preferences and important routines in high detail, and were able to give examples of how this knowledge enabled them to respond to changes in people quickly and effectively. For example, one member of staff told us about small changes they had seen in a person's style of walking had resulted in a very quick referral to a health professional and early diagnosis of and treatment for an emerging muscular issue.

Because of their complex needs, people who used the service could not always describe for themselves their choices and needs, and people we spoke with showed little interest in or engagement with their care plans. Staff we spoke with said they had time to observe and get to know people and could ensure care plans were updated whenever they learnt something new about a person's specific needs or preferences, in addition to regular formal reviews they undertook. For example, care plans we looked at contained detailed information about people's non-verbal communication. This included photographs to show staff how to make signs that each person made and understood, and we saw the care plan for a person new to the service had been amended a number of times over a short period. This meant updates to care plans were highly responsive to changes in knowledge about people's needs. Staff we spoke with were able to tell us in detail about individual needs and preferences, and said they tried to encourage people to be involved in planning and reviewing their care as much as possible.

Although there was a low level of service user engagement with their care plans, we saw there was a summary available in adapted formats, using pictorial language, short sentences and larger print sizes to increase their accessibility. Some people used technology to enable them to access information about their care. One person's weekly planner had been made available to them as a digital diary on a tablet computer because they preferred regular reassurance that activities and appointments were going to happen. This meant the person could check and reassure themselves independently of staff.

Staff told us people who used Makaton or sign language often used their own slang or dialect, and said they documented what they learnt about this to ensure all staff could communicate in ways the person recognised or preferred. This meant people were free to express themselves in ways they chose. All care plans we looked contained a high level of personalised detail which showed staff had got to know and understand people well.

During the inspection we observed staff remain focused on the safety and comfort of people who exhibited behaviours which challenged themselves and others, and we saw the overall atmosphere in the houses remained calm during such incidents. This meant staff ensured the impact on other people in the home was kept to a minimum. We saw records which showed PRN medicines prescribed to help people with periods of heightened behaviour were rarely used, meaning other interventions such as distraction and maintaining a calm environment were very successful. When we spoke with staff they told us they had the right training,

support and experience to enable them to manage challenging behaviours well. When staff described this aspect of people's care they told us how they reflected on the causes, or 'triggers' for the incident and what they could learn about the person's needs and preferences in order to minimise the occasions where the triggers were repeated. We saw care plans contained a large amount of person-specific guidance for staff to follow in order to understand how the risks posed by behaviours that challenge could be minimised by understanding potential triggers and effective distraction techniques.

Staff were able to describe ways in which they ensured people's diverse needs were explored and met, including those related to ethnicity, gender identity and sexuality. We saw this was an ongoing process – some care plans stated that some information, for example related to faith or sexuality, could not be completed because it was unclear whether the person understood these concepts or expressed any concerns or needs in these areas. This meant the provider did not make assumptions about people when planning or documenting care. Where people needed support with such areas of their lives we saw care plans had been written to ensure people had the privacy or protected time they needed. Cultural and spiritual identities were considered in the sensitive and accessible plans which people had contributed to ensure their wishes for end of life care and funeral arrangements were known and could be respected. These explored people's understanding of the concept of death, how they wished to be cared for, any spiritual or personal preferences that needed to be met in relation to the person's funeral and what the person wished to be done with their treasured possessions after death.

There were formal and informal systems in place to ensure any complaints or concerns were responded to thoroughly and openly, and we saw information about the complaints procedure and people's rights within it was clearly displayed in the home. One person told us they had made a complaint and said, "I have told the management about a problem and it was sorted quickly." We asked staff how they supported people to express concerns and complaints if they could not do so for themselves. Staff told us that if someone was unhappy about an aspect of their care or experience at Heathcotes (Wakefield), the reasons for this would be explored and changes made to their care plan if needed, for example to give clearer guidance about the person's routines. One member of staff told us, "The usual sources of frustration for people are connected with either mealtimes or when a precise routine is not met, like going out later than we had planned. Our response would be to make sure all staff know why routine is very important to people, or make sure we know that the person's needs have changed if that's the cause. I don't know whether this would get reported as a complaint or concern, though. We'd talk about care." We spoke to a senior member of staff who told us, "We recognise that when people express frustration, the cause is something that would need to be addressed as that person hasn't been happy with something. We may see it as a care issue rather than a formal complaint, and make sure we got the care right. That's how we would address these concerns." A member of staff told us, "If we had given any feedback that the senior or manager thought was a complaint I would be interviewed about it." We saw concerns and complaints were a standing item on staff meeting agendas, meaning the provider promoted open communication and learning when people or their relatives had raised issues with service provision.

People's relatives who raised complaints received written acknowledgements, and we saw records of on-going correspondence which showed there was a meaningful process in place which ensured the root cause of any complaint and on-going satisfaction with the service monitored.

People spent time planning activities with their key workers, and we saw these balanced activities in the home with those in the wider community, for example for shopping or recreational activities such as trampolining, skating, horse riding and dining out. People were the supported to produce an accessible planner to enable them to review what they had planned, and we saw people were able to change their plans if they wished. We saw knowledge of people's interests were used to enhance these activities, for

example on person who enjoyed reading had been encouraged to vary their routine to encompass shopping for books on a set day each week. Where people's conditions meant strict routines were very important to them we saw the importance of these was emphasized in care plans and we saw these were adhered to. The service was also proactive in identifying opportunities for people to increase their independence or scope of activities in the wider community. For example, we saw people had opportunities to access recreational facilities in specially arranged sessions which were adapted to their needs, and the service had developed links with a number of community, voluntary and other organisations to enable people to undertake voluntary or paid work. For example, the provider had contacted an animal charity to explore opportunities for a person with a love of animals to be able to develop their independence with some voluntary work in an area they would find interesting and enjoyable. Another person had been supported to participate in gardening activities at another organisation after they had said they had enjoying working in the grounds of Heathcotes (Wakefield).

Good

Is the service well-led?

Our findings

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. There were two registered managers in post when we inspected the service. One manager had joined the service within the last six months and was newly registered with the CQC. The other registered manager was acting in an area manager role in the organisation, and was planning to de-register from the service. We saw they had maintained regular contact with the service to support the new registered manager.

We received consistently positive feedback about leadership in the service from staff we spoke with. Comments included, "They are brilliant," "They are always supportive of the service users and the staff," "Nothing is ever too much trouble," "They are all approachable and get involved," "They respect our knowledge," "They ask about people, they listen" and "I feel valued and respected. I love my job."

Staff told us they were proud to work at the service and demonstrated a high level of commitment to the people they supported. They told us, for example, they were happy to start work early or finish late if this meant helping someone to have a 'good day'.

There was a clear sense of shared vision and purpose in the service, characterised by a strong desire to provide support tailored to the needs, abilities and preferences of people as individuals. Staff told us everyone deserved the highest quality of care, and were confident they provided it. One member of staff said, "If it wouldn't be good enough for a member of my family, then it's not good enough for the people who live here." Another member of staff told us, "We get to know the individual. That's what it's about."

Staff told us they felt highly motivated and said they received practical and pastoral support from all senior staff and managers in the service whenever they needed it, including being able to contact the management team out of hours. Staff told us all senior staff worked alongside them on the floor, and our observations showed this was the case. We found the registered managers and senior leaders all knew people's needs and characters in detail, and during the inspection we saw people were comfortable approaching or receiving support from the management team.

Everyone we spoke with who worked in the service was passionate about the work they did. One member of staff told us, "I wish I'd come into this kind of work far sooner in my life. I find myself thinking about how we can do things better after I go home, and I love that. It tells me I'm doing something worthwhile."

The service liaised well with other professionals involved in people's care and wider lives to ensure their knowledge of how to support people had the best possible foundation. For example, one person was still in education when they started to use the service. Staff from Heathcotes (Wakefield) had made visits to the person's school and spoken with teaching and support staff there in order to begin understanding how the person communicated and the kind of environment and activities they needed to provide in order to make

them feel safe and comfortable in the home. Contact had been maintained once the person started using the service, and there was evidence to show how the person's self-confidence in socialisation and participation had increased as a result of the two services sharing this information and adapting their approaches.

Staff were very aware of the value of developing and documenting detailed knowledge of people, and acted on opportunities to use that enhanced understanding to improve outcomes for people. For example, one member of staff told us, "You realise what we take for granted can be massive for them, and every time people do something they may not have tried before is a real achievement." Another member of staff said, "It's all about increasing people's confidence. If you go beyond what is expected for that person, if you get the timing right, you get people's trust and you can help them do more and more." Staff were visibly excited for people when they described how they had overcome significant challenges and had become more socialised or physically active, for example. Staff told us how these achievements had had positive benefits for people's general health and quality of life.

People were able to influence the service in both active and passive ways. Active participation was sought through regular meetings which enabled people to give feedback and make suggestions in a structured format. Agendas were prepared using accessible formats, and we saw action plans were prepared to ensure suggestions were followed up. These plans showed what would be done, by whom and by when. Actions taken as a result of suggestions made were fed back in subsequent meetings. Staff also ensured any feedback about the service from indirect means, such as a change in a person's presentation or response to a set of circumstances, was also discussed and acted on. Staff were able to give examples of how they had advocated for people in this way, and told us this feedback was always reflected in updates to people's care plans.

The provider worked to involve and listen to people's families and engage them with people's care where they wished to do so. There was an annual survey sent to families as well as other people involved in people's care, such as staff, commissioners and health professionals. The last survey had been sent in 2017, and the area manager said the 2018 survey was due to be undertaken. We saw a high level of satisfaction recorded in the responses. Families were also sent a personalised, quarterly newsletter highlighting activities people had participated in and any significant goals they had achieved.

In one dining room we saw a display of quotes from people called 'Your Voice'. This captured some of the feedback about what people liked or wanted to improve about the service. A member of staff told us, "It's nice to have that reminder there, that prompt that what we do is all about these people."

Staff were also able to contribute to the running and development of the service, and told us they felt able to make suggestions at any time. They said such feedback was always welcomed. There were also regular meetings, and staff told us they felt encouraged to share honest and open opinions which were listened to and, where needed, acted on. Meeting minutes recorded meaningful discussions taking place across a range of topics including equality and diversity, promoting dignity, reviews of people's progress and changed or changing needs and ideas for improving the service. There were action plans to show how feedback would be used to influence decisions made about the service, and feedback on actions taken was shared at subsequent meetings.

There was an excellent oversight of quality and delivery in the service, and a clear desire to identify and make improvement wherever possible. Robust processes were in place to ensure on-going monitoring and improvement in the service, and we saw these were kept up to date. Audits and other checks were used to ensure processes, for example medicines administration and management, were well managed, and there

was also provider-level audit activity which made very detailed checks of the quality of a number of areas, in particular care planning, delivery and outcomes. These processes were seen by the area manager as an important means of driving rolling improvements for people as well as for the service as a whole. For example, they told us they had identified recording of people's capacity assessments as an area which was meeting people's needs but could benefit from further improvement. We saw new documentation had been introduced as a result, which had been expanded to capture more information about communication strategies explored in the process. Improvements in understanding about effective communication with the person had been used to, and any learning from this had also been used further develop relevant care plans to ensure staff had access to up to date, person-centred guidance. The area manager told us, "We're always thinking about what we can do better."

We found the leadership team were very engaged with the inspection process. They described how they saw it as another opportunity to reflect on how the service ran, what it did well and where there may be opportunity for further improvement. Throughout the inspection we found managers and staff were all open in their communication and very keen to talk with us about the service, and we found they had a consistent focus on doing the very best for people at all times. Information about people's care and the general running of the service was well ordered, up to date and easily accessible. Staff told us they had access to information such as care plans at all times, and confirmed they had had time to read and understand care plans before they began supporting people. We saw the provider ensured staff signed to confirm they had read documentation.