Huntercombe Homes (Ilkeston) Limited

Nottingham Neurodisability Service Hucknall - Millwood

Inspection report

Hankin Street
Hucknall
Nottingham
Nottinghamshire
NG15 7RR

Tel: 01159680202
Website: www.fshc.co.uk

Date of inspection visit:
08 November 2016

Date of publication:
23 December 2016

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 8 November 2016 and was unannounced. Nottingham Neurodisability Service Hucknall provides accommodation, nursing and personal care for people who have a variety of needs associated with brain injuries. The service provides care over three units. This consists of one high dependency unit, one slow stream rehabilitation unit and one unit providing long term care. The service is registered to accommodate up to 70 people over the three units. On the day of our inspection 66 people were using the service.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 previous registered manager had left the service in June 2016 and the company's head of nursing was supporting the service at the time of the inspection until a new manager could be appointed. We were told a suitable replacement had been interviewed and was due to join the company in December 2016 who once in post would be registering with the CQC.

People were protected from the risk of abuse and staff had a good understanding of their roles and responsibilities if they suspected abuse was happening. The manager shared information with the local authority when needed.

Staffing levels were sufficient to support people's needs and people received care and support when required. People received their medicines as prescribed and the management of medicines was safe. Staff received appropriate training to assist them in their roles.

People were encouraged to make independent decisions and staff were aware of legislation to protect people who lacked capacity when decisions were made in their best interests. We also found staff were aware of the principles within the Mental Capacity Act 2005 (MCA) and had not deprived people of their liberty without applying for the required authorisation.

People were protected from the risks of inadequate nutrition and hydration. Specialist diets were provided if needed. Referrals were made to health care professionals when needed.

People were treated in a caring and respectful manner and staff delivered support in a relaxed and considerate manner. People who used the service, or their representatives, were encouraged to contribute to the planning of, and to be involved in the decisions made about, their care.

People felt they could report any concerns to the management team and they would be taken seriously. However systems in place to encourage people and their relatives to feedback their experiences of the service were not always consistent. The processes in place to monitor the quality of service had also not

been undertaken consistently.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe as the provider had systems in place to recognise and respond to allegations of abuse.

People received their medicines as prescribed and medicines were managed safely.

There was enough staff to meet people's needs in a timely manner.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training and supervision to ensure they could perform their roles and responsibilities effectively.

People were supported to make independent decisions and procedures were in place to protect people who lacked capacity to make decisions.

People were supported to maintain a nutritionally balanced dietary and fluid intake and their health was effectively monitored.

Is the service caring?

Good

The service was caring.

People's choices, likes and dislikes were respected and people were treated in a kind and caring manner.

People's privacy and dignity was supported and staff were aware of the importance of promoting people's independence.

Is the service responsive?

Good

People were supported to make complaints and concerns to the management team.

People who lived at the service, or those acting on their behalf, were involved in the planning of their care when able and staff had the necessary information to promote people's well-being.

People were supported to pursue a varied range of social activities within the home and the broader community.

Is the service well-led?

Requires Improvement

The service was not always well led.

People felt the management team were approachable and their opinions were taken into consideration. Staff felt they received a good level of support and could contribute to the running of the service.

The systems in place to monitor the quality of the service were not consistently undertaken.

There was a lack of consistent systems in place to allow people to feed back their views on the service.

Nottingham Neurodisability Service Hucknall - Millwood

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.

We visited the service on 8 November 2016, this was an unannounced inspection. The inspection team consisted of two inspectors, a specialist advisor who has experience in providing nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with nine people who used the service, six relatives, six nurses, eight members of care staff, two maintenance men, two kitchen staff and the manager. We looked at the care plans of five people and any associated daily records such as food and fluid intake charts. We looked at six staff files as well as a range of other records relating to the running of the service, such as audits, maintenance records and the medicine administration records (MAR) for people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at the service. One person told us, "Yes I feel safe with staff." They told us they trusted the staff and would be able to talk to someone if they were worried about their safety. Relatives we spoke with also told us they felt the service was safe and if they had concerns about their relations safety they would be able to speak to a member of staff.

Staff told us they felt people were safe as they had established relationships with them. All staff we spoke with demonstrated a good understanding of and commitment to safeguarding of vulnerable people. One member of staff told us of a time they had raised a concern with their manager and how it had been investigated thoroughly. A member of staff said, "We understand how to keep people safe." They went on to say, "We make sure we protect the vulnerable people." Another member of staff told us, "We've got a file (for recording whistleblowing concerns) but if you see something untoward you deal with it there and then."

Staff told us they had received training in safeguarding adults. We saw records that confirmed this and that further training was planned. Staff told us the training had been helpful in understanding the different types of abuse and how they should deal with any issues that compromised the safety of the people they cared for.

The manager was aware of their responsibilities and we saw that any safeguarding issues had been shared with the local authority and ourselves with clear records of investigations and lessons learned. The manager told us they were confident that staff would raise issues of concern so they could be dealt with appropriately.

Staff we spoke with were able to tell us how they managed risks to people's safety. One staff member told us that risk assessments were in individual's care plans and they were able to access them when required. They told us if a person's needs changed this was discussed at handover meetings and staff would be encouraged to read the changes in the care plans. Throughout the visit we saw staff using equipment confidently and safely. Staff confirmed they had received the appropriate training to use the equipment. One person we spoke with told us they had the equipment they needed to keep them safe and mobile. We saw the person had a wheelchair that they were able to manoeuvre themselves.

The risks to people's safety was assessed when they were admitted to the service and reviewed regularly. We viewed a number of care plans and saw detailed risk assessments in place for individuals relating to elements of their care such as moving and handling, falls, tissue viability and nutrition. For example one person's file noted that specialist equipment was needed to assist them with their mobility, including the type of bed and chair they required to allow them to sit comfortably whilst being supported. During our inspection we saw that the person had access to this equipment.

One person had been assessed as being at high risk of developing tissue damage. The accompanying care plan gave detailed information on how staff could prevent this. Where appropriate, care plans contained up to date body maps to show staff which areas of the person's body were most at risk of developing tissue

damage and how the person should be treated to prevent this.

People could be assured the environment was safe. The service had two maintenance people who oversaw servicing of essential equipment and we saw the corridors were uncluttered and free of trip hazards.

The majority of people we spoke with felt there was enough staff employed to meet their needs. However, some people told us that at particular times in the day they were kept waiting for care. One relative told us their relation could wait for up to an hour for personal care. However they also said that staff were generally quick to answer buzzers. Another person said, "Staff can't always get to you straight away if they are dealing with someone else." But they added that staff tried not to keep them waiting.

Staff we spoke with felt in general there was enough staff, but told us things could sometimes be tight. One staff member said, "It's just started to even out." They told us they had been short staffed in the past but the manager had tried to support them and they had tried different ways of managing the workload such as having extra staff to make breakfasts and assist with bed making. Other staff told us when people required one to one care the manager ensured this was in place. They said, "We have to have allocated staff to meet people's one to one needs so we are pretty safe." Another staff member who worked on the high dependency unit said, "(The unit was) Always fully staffed." They went on to say that staff worked hard on their time management approach to ensure people got the most effective care.

The registered nurses we spoke with told us their job was demanding and they sometimes struggled to complete the office work they were required to undertake. This included writing, updating and revising care plans, essential audits and analysis of incidents. One staff member said, "There's enough staff but nurses need more time off the floor (supernumerary) to help the (unit) managers with all the admin, (administration work)." The registered nurses told us the manager did try to support them and when we spoke to the manager she told us she had escalated this issue to more senior management and worked with the registered nurses to try to ensure they got the time they needed to undertake this essential work. We saw that the senior management had taken steps to address this. For example, unit managers were allocated up to 22 hours supernumerary shifts per week to help them complete administration work

The provider had a system in place to assess the number of staff required for each unit and each shift. This was based on the dependency of people using the service and the number of care hours allocated to people by their care provider. The manager told us as well as their permanent staff they had a core of bank staff to cover unforeseen circumstances such as short notice sickness. The manager offered overtime to permanent staff and when needed used agency staff to cover shortfalls. The manager told us they used a particular agency and always tried to get staff who had worked at the home in the past. We viewed a range of staff rotas which showed the planned numbers of staff were met majority of the time. Staff we spoke with confirmed that the manager and unit managers always tried to cover short falls of staff.

People could be assured they were cared for by people who had undergone the necessary pre-employment checks. We examined six staff files and saw the provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks through the Disclosure and Barring Service (DBS), as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

People had their medicines administered by staff who had been appropriately trained in the safe handling of medicines. One relative we spoke with told us they felt medicines were given on time. Staff we spoke with told us they had received adequate training to help ensure they were able to manage and administer medicines safely and that senior staff regularly completed assessments of their competency to do so. One

member of staff told us "We have regular (face to face) training and have to complete online training as well." They went on to say, "We have a pharmacy inspection as well. Anything they say needs changing we do."

We observed two medicines round and saw the staff members followed safe practices and ensured each person took their medicines. Some people required their medicines in liquid form or their tablets to be crushed we saw the relevant documentation in place to show advice had been sought from the GP and pharmacist so the medicines were administered safely. No one required covert administration of medicines but staff were aware of the correct processes they would follow should they need to. We saw medicines were stored correctly and records relating to administration and ordering were up to date.

Good

Is the service effective?

Our findings

People could be assured the staff who worked in the service received regular on-going training to ensure they had the skills to undertake their roles. Relatives we spoke with told us staff appeared to have the right training for the job they under took. One relative said, "Staff are very good with challenging behaviour." Another told us that staff had told them they received regular training.

Staff we spoke with felt they had sufficient training to enable them to meet people's needs. Staff told us they received an induction to the service and to each new unit they worked on. One member of staff we spoke with told us they were up to date with their training identified as mandatory by the provider and had also undertaken additional training on a number of specific clinical skills they required for their role. Another member of staff said, "Yes we've got enough (training). I think if you wanted anymore and requested it they'd (managers) look into it." They went on to say they had requested additional role specific training and the managers had booked it for them.

A senior member of staff told us, "We make sure all the staff have the same level of training across the units so they all have the same level of skill." We were also told that the associated medical staff provided training to help staff better understand and meet the complex needs of the people who used the service. We saw a number of posters on the wall in the units and entries in communication diaries saying when these sessions would take place and what they were about. A member of staff said, "Once a month the clinical psychologist does a training session on mental health plus they are always around so we can ask them anything."

Staff told us they received appropriate training when new equipment was brought into the service. a member of staff said, "If someone's needs change or they need a new piece of equipment, the physiotherapist, or occupational therapist will do a session so we all know we are doing it right."

We viewed the service training matrix and saw that a rolling training was in place. This showed 90% of staff were up to date in areas such as, health and safety, infection control, the mental capacity act, moving and handling and safeguarding vulnerable adults. There was also on-going plans to ensure all staff kept themselves up to date with their mandatory training.

We saw that staff were supported by the management team. There was a schedule for staff to receive one to one supervision from their line managers and staff confirmed they were supported with regular supervision and appraisals. They told us the meetings were supportive, and useful. One member of staff told us, "Seniors (nurses) get support from the unit manager and seniors support other staff." They went on to say, "It's good, there's not a lot to moan about, but it's good to discuss bringing in new ideas and things we can do."

People were supported to consent to their care. One person we spoke with told us, "Yes they ask me what I want and then do it." Staff told us that although some people couldn't verbally tell them what they wanted they followed visual cues from people when providing care. One staff member said, "We talk to people, I look at facial expressions, I explain things. I would record if someone didn't want care and try again later."

Our observations supported what we had been told by people and staff. For example we heard staff talking compassionately to non-responsive service users and asking people with very limited ability to respond for permission and consent to interventions as well as thanking them for their cooperation.

People could be assured that staff followed the principles of the Mental Capacity Act 2005 (MCA). The 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.

There were assessments of people's capacity to make decisions and to give informed consent in their care plans. These assessments were detailed and individualised. There was information in place to highlight where people may need help in deciding what they wanted to do in relation to various aspects of their day to day care. For example we saw one person had been assessed to show they had the mental capacity to make their own decisions about their day to day and medical choices. The person had safety measures put in place to prevent them from falling, however they had refused some aspects of the safety measures as they felt they had sufficient movement to keep themselves safe. A risk assessment and been put into the care plan and the person's wishes had been respected.

The focus of the assessments was on what decisions people could make and how staff should assist them. Staff we spoke with showed a good knowledge of the MCA. One member of staff told us, "The people who live here have a choice in their daily lives and we start from the point that a person has capacity to make their own decisions."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw a number of applications to the local authority awaiting assessments relating to DoLS in people's care plans. We saw completed authorisations and noted the conditions of the authorisations were being met. The service had good systems in place to review mental capacity assessments and reapply for DoLS when they expired. The nurses and unit manager we spoke with told us they had received useful training on both recently.

People's nutritional needs were well managed and they were supported to get enough to eat and drink. One person told us the food was good and that their relative also provided snacks and bottled water, but they told us these were also available in the service. We saw the kitchen dining areas had snacks and hot and cold drinks available for people on the different units.

We observed two mealtimes. Where people needed assistance to eat, it was provided on a one to one basis in a discreet and unrushed manner. Adaptive equipment such as plate guards were available when needed to aid people's independence. We found that where people had been assessed as needing special diets, for example diabetic, soft or pureed food, these were recorded in people's care plans and catered for. There was good communication between the kitchen staff and care staff to ensure people received the correct diets. One member of staff told us they had been trained to assist people who were at risk of choking. They said, "We are told how to position people and how much to put on a spoon etc." They told us the Speech and Language team (SALT) came in and gave them feedback on their practices

Where necessary advice from health professionals such as dietitians and nutritionists had been sought to

ensure people received the best nutritional support. Staff told us people's needs changed and when there were improvements in people's health conditions relating to nutrition they altered their diets to accommodate this with on-going specialist advice.

People told us they had access to health care professionals when they needed them. One person told us, "I have never had any problems, if I need a doctor they (staff) send for one." Staff told us they felt people's health needs were well managed. One member of staff said, "(if someone was ill) We would tell the nurse and they sort things quickly." The member of staff then went on to discuss a person who required regular monitoring for an on-going health condition. They explained they knew what to look out for and report to the nurse. We saw that staff used their skill and knowledge of people's needs to ensure everyone had access to healthcare when required. A staff member told us, "We do regular (recording of) vital signs. So if they are out of sync we can get the doctor because not everyone can communicate verbally". Staff also told us they kept relatives informed of any health issues and worked with health professionals such as the tissue viability nurses to manage specific issues.

During our visit we saw a number of people had on-going significant health needs. The staff we spoke with were very knowledgeable about the different treatments people required. We saw registered nurses had the knowledge to manage health issues of the people they supported to ensure particular problems did not escalate to cause people un-necessary discomfort.

There were also examples in people's care records of timely referral to other health professionals when required such as GP's, or dentists. This was alongside the regular therapy interventions provided at the service by physiotherapy, occupational therapy and speech and language therapy.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were caring and compassionate. One person said, "They are a good bunch (of staff) they are all very nice." Another person who was not able to communicate verbally was able to respond with hand signals, and they were able to indicate they were "content and cared for." Their relative told us they felt the staff were kind to their relation, they told us staff took an interest in the person and considered their wellbeing, staff knew what the person liked and ensured this was arranged for them. For example the person enjoyed watching DVD's and staff would go into the room to make sure the person had the DVDs they wanted playing. Other relatives told us that staff were kind and caring one relative said, "They love (my relative)."

Relatives told us they were made to feel welcome in the service, one relative said, "This place is marvellous." They felt the staff cared about them as well as their relation, they said, "They make us a drink." They went on to say, "If I were to become ill I would want to come here and be cared for too."

Staff we spoke with told us they enjoyed working at the service and felt there was a culture of kindness among their colleagues. One member of staff said "We do our best for them." (the people they supported). Our observations supported these comments we saw many examples of caring relationships between staff and people using the service. One person was clearly distressed at one point during out visit and was shouting in the communal areas. Staff demonstrated kindness and compassion in reassuring the person and walking with then whilst they were upset. Although it took some time to calm the person the staff member with them remained patient and spoke at intervals with the person helping to gently calm them.

We witnessed a further example when the nurse in charge of one unit received two family members on to the unit whose relative had died recently. The nurse made the family their priority, welcoming them, giving them their office, supplying drinks and a lot of emotional support. Staff showed empathy towards the people they cared for and their relatives and when they received positive feedback from a relative one member of staff was visibly moved.

People's views and opinions on how they received their care were encouraged by the staff in the service. There were systems in place to, where possible, involve people in their care if people were not able to express a view or struggled to make their opinions known then staff involved their relatives in planning their care.

Staff we spoke with were able to give examples of how people's views and choices were respected and we also saw evidence in care plans. For example one person had said they would rather have their breakfast before having a shower each day and their routine was changed to accommodate this. One staff member said, "There's no set routine at all. People get up when they want and go to bed when they want."

Staff understood and respected people's cultural and religious need and tried to ensure these were met. A relative we spoke with told us this had been very important to them as their relative had a strong religious faith. We saw people received regular visits from their religious leaders and a further example of cultural

needs being met was a person was provided with meals that reflected their faith.

People had access to advocacy services if they were required and the manager understood their responsibilities in ensuring this was accessible for people using the service. They told us one person in the service was using the services of an independent mental capacity advocate (IMCA). An IMCA is a trained professional who supports, enables and empowers people to speak up.

People we spoke with told us staff respected their privacy and treated them in a dignified way. One person said. "Yes I have no issues with this." When asked if their privacy was respected. Relatives we spoke with told us staff spoke respectfully to their relation.

Staff we spoke with were aware of their responsibilities in maintaining people's privacy and dignity. One staff member told us, "There's a care plan for it (privacy and dignity) but it's something we just do naturally." They went on to say, "We close doors, explain what we are about to do, make sure people understand and make sure they are covered up."

During our visit we saw that when staff assisted people with their personal needs the interactions were undertaken in a caring and patient way which promoted people's dignity and protected their privacy. Staff spoke to people in a discreet manner about any issues of a personal nature and provided people with the time to respond.

Good

Is the service responsive?

Our findings

People felt their individual needs were known by staff and they could make independent decisions in relation to their daily routines. One person told us they weren't bothered about reading their care plan but that staff went through their care needs when they first came to the service. They told us new staff also seemed to know what their needs were. One relative we spoke with told us they were "very much so" involved in the care plans and had attended a multidisciplinary team meeting the week previously to discuss the ongoing needs of their relation. The relative said, "Our wishes are taken into consideration at these meetings."

Staff told us effective communication systems were in place to ensure they were aware of people's individual needs and preferences as soon as they were admitted to the service so person centred care could be given. One member of staff told us they were given time out each day to read different care plans, either of people who had just come to the unit or if there were changes to people's needs. They said they were told about changes at handovers and things would be written in the communication book so they could be sure they kept up to date with the changes to people's care. Staff told us the care plans were helpful and they always tried to involve people and their relatives in planning and reviewing care. One member of staff said, "You can involve the family and some people have full capacity so they are involved." The member of staff went on to explain when reviewing care plans they would ask the person or their relative if they want any changes to the care plan and then include them.

We saw where people required clinical interventions there was supporting information for staff to ensure safe practice. The service also had an on-site therapy team consisting of a Speech and language team (SALT), Occupational therapists and Physiotherapists. This meant people received the rehabilitation and support they required without the service needing to make referrals to the relevant teams. There were appropriate policies and protocols in place both as hard copies and on line. There was a folder issued by the NHS available for staff related to particular feeding methods which contained guidance on clinical practice. The folder also contained professional articles regarding current evidence based practice and advice about possible early and late complications relating to this method of nutrition.

The care plans we reviewed were person centred, regularly updated and gave sufficient information to enable staff to understand and deliver care and support people required. For example when we reviewed one care plan we saw the person had a recent health issue and had been reviewed by the GP. The care plan identified the treatments in place and the practices staff should use to lessen the impact of the health issue. We saw another care plan that had assessed a person as being at risk of tissue damage. The care plan gave clear information regarding the areas of the person's body that was at risk and how this should be managed. The person's relatives told us staff had managed their relation's care well, they said, "Look at (name) there isn't a mark on them." This showed staff used the information in the care plans to give effective care.

People we spoke with told us that whilst there were activities taking place they sometimes felt bored. However we saw there were activities available for people should they wish to take part. During our visit we saw the activities coordinator working with the physiotherapist and occupational therapist to organise a

baking session. A number of people were involved and the staff worked to ensure people could participate whatever the level of their ability. The cakes that were made were used for the afternoon tea. The session was well organised and the people taking part appeared to enjoy themselves.

The information in the care plans we viewed with regard to people's social activities showed how individuals were supported to ensure they did not become isolated. One person's plan identified a number of activity interventions including the use of a lap top and the assistance to write letters, attending the hairdresser and physiotherapy in the gym. During our visit we saw the person having physiotherapy in the gym and enjoy a visit from friends in their own room the person told us they were happy with their environment and the care they received from staff.

People felt they were able to say if anything was not right for them. They felt comfortable in highlighting any concerns to the staff and believed their concerns would be responded to in an appropriate way. One person told us, "If I've got a complaint I tell the nurse in charge, they sort stuff out." The person went on to say they had not had any big complaints only niggles but they were addressed. A relative we spoke with told they wouldn't have any problems raising concerns they would just email the unit manager or even the doctor who attended the unit. They told us they had been given email contacts for these people. The relative also told us they hadn't any need to complain.

There was a complaints procedure for staff to follow. Staff felt confident that, should a concern be raised with them, they could discuss it with the management team. They also felt complaints would be responded to appropriately and taken seriously.

Records showed that when complaints had been received they had been recorded in the complaints log and managed in accordance with the organisations policies and procedures.

Requires Improvement

Is the service well-led?

Our findings

At the time of our visit the service did not have a registered manager in post. The last registered manager had left the company in June 2016. A temporary manager had been employed during the interim who had left the service in September 2016. At the time of the inspection the company's head of nursing was working as the temporary manager to support the service until the appointment of a new manager who would be required to register with us. The company had interviewed and appointed a new manager who would start in their post towards the end of December 2016. We found the present manager was clear about their responsibilities and they had notified us of significant events in the service.

People and their relatives told us the present manager was a visible presence in the service. One relative told us they were able to talk to the manager when they needed to and they knew them by name. People and relatives we spoke with were also able to tell us who was the person in charge of their particular unit.

Staff we spoke with felt the manager and heads of units were supportive and approachable. One staff member told us they had joined the service after qualifying as a nurse. They told us it had been a bit daunting at first but everyone had been helpful. Any questions they had, senior staff had answered patiently and ensured the nurse was supported as they familiarised themselves with the unit and their role.

Staff told us they enjoyed working at the service. During our visit we observed staff working well together and they promoted an inclusive environment where friendly chit chat was being undertaken between staff and people who used the service. We saw staff were supporting each other and it was evident that an effective team spirit had been developed. Staff we spoke with had an understanding of the company's whistle blowing policy and told us they would feel able to use the policy should they require it.

The management team had clear roles and responsibilities and worked with the multidisciplinary team to provide good care for people. For example the manager and heads of each unit met at 9am each morning to discuss any issues which had arisen in the previous 24 hours and what was planned for people for that day including any appointments or multidisciplinary meetings for individuals. This meant that not only were heads of the units aware of any pressures or concerns from other units the manager had a clear overview of what was going on in the service on a day to day basis.

Whilst each of the heads of unit communicated and supported each other, due to the different nature of the needs of people on the units, there were some good practices that were not always shared across the service. For example one unit held regular staff meetings to review polices and procedure. Another unit held a Monday morning meeting for senior staff to discuss any developments from the weekend and plans for the week ahead. The staff on the unit felt this meeting was useful.

Although systems were in place for people and relatives to give feedback about their experiences of the service, this was not consistently applied across all units. One relative we spoke with told us residents meetings for people across the three units had started recently. But they had not seen any minutes of the

meeting and there had been no agenda. They felt having one meeting for the three units together was not helpful and the timing of the meeting had meant it was difficult for people to attend. However we saw records of two residents meeting arranged by therapy staff for residents and relatives from one unit. Issues people had raised from these meetings were acted upon by staff. For example people requested more time in the garden and greater frequency of visits by the hairdresser, both of which had been arranged. This meant the service did not have a consistent system in place for all the people who used the service.

We discussed these disparities with the manager who agreed that some good managerial practices were not always coordinated to ensure the whole service benefited. They explained that whilst they supported the service they still had responsibilities from their substantive role. This had had impacted their time and therefore their ability to introduce and standardise good practices across the service. However they also told us that what might be beneficial for one unit may not be appropriate for another. They told us when the new manager came into post they would be able to monitor management initiatives more closely and ensure each unit undertook the best practices for the people in their areas.

Audits related to quality monitoring in the service had not been consistently undertaken in the previous months since the last registered manager had left the service. Whilst we saw there were some systems in place such as audits of the environment, audits of care plans, Falls analysis and medicines management at managerial level had not been undertaken consistently in the previous months. The manager told us they were aware of the issue but due to their combined responsibilities in the company they had not had the time and resources to address these short comings. This meant there had been a lack of consistent provider oversight of the service.