Plans4Rehab Limited

Barclay House

Inspection report

165 Barclay Street
Leicester
Leicestershire
LE3 0JE

Tel: 07905587029
Website: www.plans4rehab.com

Date of inspection visit:
20 December 2016

Date of publication:
28 February 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection visit took place on 20 December 2016 and was unannounced. This was our first inspection of the service since they registered with us.

Barclay House provides accommodation and personal care for people with an acquired brain injury, stroke or other neurological conditions. The service provides care and rehabilitation for people through an outreach service or through short and long-term rehabilitation placements with a view to returning home wherever possible. The service is able to accommodate up to 18 people and is situated close to the centre of Leicester. At the time of our inspection there were 12 people using the service.

The service has a registered manager. 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 good systems and processes in place to keep people safe. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe.

The registered manager made sure there were enough staff to meet people's needs as detailed in their care plans. The registered manager followed the provider's safe recruitment practices. This helped to ensure people were cared for by staff who were suitable for their role.

People were supported to take their medicines safely. However, we found further improvements were needed to the storage and recording of medicines to ensure people's medicines were stored and managed safely.

Staff told us they felt supported in their roles and the registered manager provided staff with clear guidance and leadership. Staff had completed the training and qualifications they needed and we saw they used this knowledge to provide people with safe and effective care.

Staff understood the relevant requirements of the Mental Capacity Act (2005) and how it applied to people in their care. People's individuality was at the centre of how their care was delivered. Where people had been assessed as having mental capacity, they were fully involved in making decisions about their care. Where people lacked mental capacity, further work was required to ensure all decisions made were in the person's best interests.

People had their health needs assessed and detailed care plans were put in place to meet their needs. Staff worked with a range of internal and external healthcare professionals to obtain specialist advice and support about people's care. Staff supported people to have sufficient to eat and drink and manage their

complex health conditions. This meant that people received support to maintain their health and well-being.

Staff were caring, patient and attentive in their approach to meeting people's needs. Staff knew people well and took time to chat with them and provide assurance.

Staff maintained people's privacy and dignity whilst encouraging them to be as independent as possible. People were involved in making decisions about their own care.

People's care plans were person centred, detailed and written in a way that described their individual care and support needs in detail. There were regularly reviewed and changes made where required. Care plans were accessed by staff and internal health professionals. This meant everyone was clear about how people were to be supported and their personal objectives met. People and those important to them were involved in deciding how they wanted their care to be delivered.

People were able to access a range of therapeutic activities which were provided based on individual aspirations, needs and interests.

The provider had a clear complaints policy which provided people and their relatives with clear information about how to raise any concerns and how they would be managed.

People and staff thought the service was well managed. Staff spoke positively about the registered manager and felt involved in the running and development of the service. People and their relatives were provided with a range of opportunities to share their views about the service.

The registered manager undertook regular checks on the quality and safety of the service. The registered manager was committed to providing high quality care to people and improving and developing the service to meet people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not consistently stored or recorded safely. People using the service felt safe and staff knew what to do if they had concerns about their welfare. Risks to people had been assessed and managed. There were enough staff to meet the needs of people the service supported.

Is the service effective?

Good

The service was effective.

People received effective care from staff who had the skills and knowledge to meet their needs. Staff understood the principles of the Mental Capacity Act 2005. Where people had mental capacity, they had consented to their care and treatment.

Further work was required to ensure that, where people lacked mental capacity, decisions had been made in their best interests. People were supported to have sufficient to eat, drink and maintain a balanced diet. People were assisted to access healthcare services and maintain good health.

Is the service caring?

Good

The service was caring.

Staff had developed positive caring relationships with people. Staff knew the people they were caring for and how they liked to be supported. People were treated with dignity and respect and their right to privacy was upheld. People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Each person received a service that had been tailored to meet their needs and wishes. People's care was kept under review and adapted as people's needs changed over time. People were supported to undertake activities that they enjoyed and which

were of benefit to their well-being. There was a complaints procedure in place and the service was responsive to people's concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager had promoted a culture that focussed on people. The registered manager had demonstrated clear leadership and was committed to ensuring people received high quality care.

Barclay House

Detailed findings

Background to this inspection

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

This inspection took place on 20 December 2016 and was unannounced.

The inspection team consisted of one inspector and a specialist advisor. A specialist advisor is a person with professional expertise in care and treatment. The specialist advisor for this inspection was a nurse whose area of expertise was in brain injury and neurological conditions.

Before the inspection we reviewed the provider's statement of purpose and the notifications the provider had sent us. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

During the inspection we spoke with four people using the service, one nurse who was the clinical lead, an agency nurse, one occupational therapist, three care staff, the cook and the registered manager. We also observed people being supported in communal areas.

We looked in detail at the care records of three people using the service and a range of documentation about the care, staffing and quality assurance for the service. These included records pertaining to the management of medicines, complaints, accidents and incidents and minutes of meetings. We also looked at staff training records and recruitment files for two members of staff.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person told us, "I feel safe here because there are a lot of people (staff) around and it's given me confidence."

Staff we spoke with told us with confidence that they understood the provider's procedure to follow in order to safeguard (protect from abuse) people from harm. Staff knew how to report any concerns within the service or to external agencies. One staff member told us, "People are kept safe through a variety of monitoring and recording systems. I am aware of the safeguarding policy and know I can report any concerns to the nurses or the registered manager. I can also go outside of the service, for example, report to safeguarding authority or CQC if I felt my concerns were not being taken seriously."

Staff told us and we saw records that confirmed they had received training in how to recognise and protect people from abuse. Staff we spoke with told us they felt able to report any concerns to the registered manager and were confident they would be dealt with in a timely manner. This showed that staff understood the possible signs of abuse and how to protect people from harm.

We found people were protected from risks associated with their care because risk assessments had been undertaken which provided guidance and support for staff to keep people safe. Risk assessments identified the level of risks and the measures staff needed to take to minimise risk. Risk assessments included risks associated with activities, such as going out of the service and with people's health conditions. For example, one person was assessed as requiring bed rails to reduce the risk of falling out of bed. We saw the assessment had identified the person could be at risk of injury or entrapment from the bed rails and included guidance for staff to ensure padding was fitted correctly to reduce the risk. We saw that risk assessments had been reviewed and updated as necessary. This meant current risks people faced were underpinned by up to date written guidelines to ensure people were kept safe.

The registered manager monitored and reviewed accidents and incidents within the service. This enabled them to take action when necessary to reduce the risk of similar incidents from happening again. For example, we saw one incident where a person had accessed the external grounds of the premises unaccompanied. The person's risk assessment identified that they required a staff member to accompany them outside of the service due to the risks they faced in going out alone. The registered manager had arranged for additional security measures to be fitted to external exits to reduce the risk of the person coming to harm whilst not restricting their freedom of movement. Records that we saw showed the registered manager collected information from accidents and incidents as part of their regular audits and analysed these to identify if there were any trends or patterns. This helped to ensure people were kept safe within the service.

People and staff told us they were happy with staffing levels within the service and felt there were enough staff available to deliver a good service and meet people's needs. One person told us, "There is always enough staff around to help me." One staff member told us, "We do have enough staff around. Sometimes we have to use agency nurses but we always use the same ones so they know the service and people receive

consistent support."

During our inspection we saw that the atmosphere was calm and staff did not appear overly rushed. Staff had time to speak with people and to check that people across all areas of the service were safe. There were staff present in and around corridors so that people who needed reassurance were helped to find where they wanted to go or were provided with assistance. The registered manager told us that staffing levels were determined by the dependency needs of the people using the service and were flexible to meet people's changing needs and reviewed when new people began to use the service. This meant there were always enough staff around to meet people's needs and keep them safe.

We saw that the provider had records to demonstrate safe recruitment practices. We saw and staff confirmed they had received pre-employment checks before they began working in the service. Checks included evidence of previous employment, proof of identification and a check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with adults who use health and social care services. This showed that the provider followed procedures to ensure staff were suitable to work in the service.

We looked at how people were supported to manage their medicines. The nurse on shift was responsible for the administration of medicines. Medicines were stored securely although we found that temperatures of storage areas were not taken consistently. For example, records we saw showed that temperature checks for refrigerated medicines were, on occasions, much higher than the recommended maximum temperature for the safe storage of temperature controlled medicines. Records did not provide clarity in terms of actual temperature recordings for the fridge and the nurse we spoke with was unclear of the ideal temperature range for these medicines. The clinical lead told us they had ordered a new fridge because a larger one was needed and they would ensure temperatures were within the recommended limits. This is important to ensure people's medicines are stored safely and within the recommended temperatures.

We saw that topical medicines, such as creams and lotions were not always marked with the date of opening. This is important to ensure the medicine was safe to use as some medicines have a limited expiry date. For instance, we found topical medicines for two people had been opened but had not been marked with the date of opening. We found a third topical medicine for a person was in use but had exceeded the manufacturers use by date. We discussed these concerns with the clinical lead who told us they would ensure all medicines were marked with date of opening and not used beyond their expiry date in future.

We observed a nurse supporting people to take their medicines during our inspection visit. We saw this was done safely. The nurse approached people individually and asked them if they would like to take their medicines, telling them what they were for. People were given time to take their medicines in the way they wanted to and no-one was rushed.

We looked at a sample of Medicine Administration Records (MARs) and found records were accurate and completed in line with people's prescribed medicines. However, we found that records of medicines kept in stock were not always completed accurately. For instance, we found that one person's medicines exceeded the recorded stock level by one tablet. We also found another person's medicines exceeded the recorded stock level by five tablets. Records showed that medicines had been counted and checked three days before our inspection visit. This meant that records were not always completed accurately to show people medicines were stored and managed as prescribed.

The clinical lead told us they were in the process of implementing a new audit system which would improve

how medicines were checked in and added to stock records. They told us they would work with nurses to ensure records were completed accurately and consistently. This would help to ensure people's medicines were stored and managed safely.

Good

Is the service effective?

Our findings

People had confidence that staff had the skills and knowledge to meet their needs. One person told us, "They (staff) help you with a lot of things, like using the gym, and they helped me to start walking again. The staff support me to actually do things and learn things whilst I am here. I'm not just sitting around, feeling bored and old."

All the staff we spoke with told us they received a variety of training to enable them to carry out their job effectively. They demonstrated they understood the specific needs of people living with a neurological condition and how to respond when people became distressed, agitated or confused. All staff had completed training in acquired brain injuries and rehabilitation. One staff member we spoke with told us, "I had a lot of training that I had undertaken in my previous employment that was relevant to this role but I had not had any training in supporting people with acquired brain injuries (ABI). The ABI training that I received from [name of registered manager] was very good. It provided me with the knowledge I need to support people and it's refreshed regularly." Another staff member said, "If there is any training we need, it's provided. I have all my mandatory training and additional specialist training, such as supporting people whose behaviours challenge. I received training in all aspects of ABI with [name of registered manager]."

Staff training records that we saw showed staff training was regularly monitored and reviewed, including dates when training needed to be refreshed. For example, staff completed feedback sheets at the end of each training session to enable them to identify what they had learnt, how they intended to put this into practice and what additional support they may need. Feedback sheets were reviewed by the registered manager and used to inform the training schedule. For example, we saw a sample of feedback sheets after ABI training. The registered manager told us they used the evaluation and feedback to plan future training for staff. Staff told us their training and development needs were also discussed during supervision sessions. This helped to ensure training supported staff to provide effective care.

We saw that staff were provided with and completed an induction before they started working for the service. The registered manager advised us that new staff completed the Care Certificate. This is a nationally recognised qualification that sets fundamental standards for the induction of adult social care workers. Staff spoke positively about their induction into the service. One staff member told us, "My induction was based on the work I am doing. I was shown around the premises, talked through the policies and procedures and introduced to people and staff. I had time to read people's care plans and notes and work with other staff to learn what people liked and didn't like."

All the staff we spoke with told us they felt supported in their roles. One staff member told us, "She [registered manager] is very approachable. Although she is busy, I feel I can go to her if I need advice and she has the time for me. She runs a tight ship and has high standards which we are all encouraged to follow. I feel supported." Another staff member told us that they received regular supervisions with the registered manager and also felt the team supported each other. This showed that staff had the support they needed in their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff understood what was meant by a deprivation of a person's liberty and staff had undertaken training in this. DoLS applications had been made and authorisations were in place for people to ensure they were not deprived of their liberty unnecessarily. This was in relation to people requiring constant supervision and decisions to use the service. Recordings we saw showed that staff were providing care in line with people's authorisations which were reviewed on a regular basis.

We looked at how people's consent to care and treatment was sought in line with legislation and guidance. People's care plans included their aspirations and wishes and capacity to consent to their care. We saw that best interest decisions were made through internal health professionals meeting together on a regular basis. Minutes of meetings showed input from the person, where relevant, their family and other professionals such as the registered manager, doctors and specialist health professionals. Best interest decisions were used to update the person's care plan and the care that staff provided.

Where people were assessed as lacking mental capacity, there was little recorded evidence to show that any decisions made on the person's behalf was in their best interest. For example, where people were engaged in specific activities as part of their rehabilitation, decisions had been made through internal meetings involving health professionals but had not been externally validated by an independent best interests assessor. A best interest assessor is an approved health or social care professional who has undertaken the required training and experience in order to undertake best interests assessments. They must not be involved in the care or treatment of the person, therefore providing an independent assessment in the person's best interest.

We discussed best interest decisions with the registered manager who told us that work was already underway to ensure, where people lacked mental capacity, decisions made on their behalf were in their best interest. They told us that in additional to internal best interest meetings, there were advocacy services available that they would make use of. Advocacy is an independent service that supports and enables people to express their views and concerns. This would help ensure that, where people lacked capacity, decisions made on their behalf were in their best interests.

People told us they enjoyed the meals at the service. The cook explained that they provided a set menu where people could choose from a range of dishes. Written menus were also supported by pictorial menus to support people to make choices about what they wanted to eat. Staff provided the cook with information about special diets and also likes and dislikes. The cook told us, "Staff update people's likes and dislikes regularly as due to their health conditions, this can change from day to day. I make sure I take these into account when I'm cooking people's meals."

A range of snacks and drinks were available to people. People were encouraged to access drinks from a dispenser in the communal areas or staff ensured people were supported to have sufficient drinks and snacks throughout the day.

We observed that people were able to choose what they wanted for breakfast. For example, one person needed encouragement to eat. We saw that they were provided with their favourite breakfast. The person told us the food was good and they were happy the cook had made the meal for them. The cook explained that they were able to provide people with meals in line with their cultural needs, for example, halal or kosher, and that relatives were invited to have meals with their family members if they wished. Wherever possible, meals were protected (no visitors allowed) to ensure people received the help they needed to eat their meals without intrusion.

We observed the lunch-time service to understand people's meal experience. Where people required support to eat and drink, this was provided in a sensitive and timely manner. For example, one person required support to eat their meal. We saw that a staff member sat next to the person and supported them to eat at their own pace. The staff member engaged in conversation with the person and encouraged the person to take hold of the cutlery as they guided the food to the person's mouth, asking them, "Do you want to try?" The person held onto the cutlery and was encouraged to participate as much as they could. Another person's care records assessed that they were at risk of choking if they were not supervised and supported during eating and drinking. We observed the person supported to have a drink by a staff member. The staff member held the cup with the person and supported them to drink slowly so as to reduce the risk of choking. This showed that staff followed people's care plans to ensure people received effective support with their meals and drinks.

Staff were able to describe what they did to help people maintain good health. Many of the people using the service had complex health conditions. Staff explained how they provided feedback either to the registered manager, nurse or on-site health professionals if they observed a change in someone's condition. One staff member told us, "The daily care notes are shared with all on-site professionals, the physiotherapist, the occupational therapist and the SALT (Speech And Language Team). This means that any changes in the person's needs can be quickly identified and responded to. The care plans are reviewed and updated and everyone is aware of the change in the person's needs so the person receives consistent and effective care." The staff member was able to provide an example where a person no longer used a peg feed (a tube inserted into the person's stomach) and was now on solid foods. This was largely due to the support staff provided which had resulted in an improvement in the person's health condition and overall well-being.

People's health care needs were assessed and detailed care plans put in place to meet their needs. Care plans included rehabilitation programmes. For example, where one person had the aim of walking again, we saw their care plan included detailed assessments as to the level of physiotherapy support they required. This included specialist equipment and access to the gym to enable them to develop the skills they needed. The person told us, "They (staff) have helped me to walk again. Before I came here, I couldn't walk. Staff have helped me to use the equipment in the gym to build up my muscles and strength. I like the treadmill best." We observed the person supported to access the gym with the physiotherapist. The person told us they were looking forward to their session.

People were supported to access a range of on-site services such as physiotherapy, speech and language, occupational therapy and a psychiatrist. Where people required specific support to manage their health conditions, they were supported to attend external appointments. This helped to provide people with the support they needed to maintain and develop their health and well-being.

Good

Is the service caring?

Our findings

People were happy with the care they received from the service. One person told us, "The staff are good here, they help me a lot." Another person told us that they felt the staff were "good."

We observed that staff treated people with respect. For example, when staff supported people with their meals and personal care needs. We saw that staff spoke with people before providing care to them, consulting them as to what they wanted to do and if they were ready for support. We also saw staff spoke with people after support was given to check they were happy. We observed shared humour and interactions between people and staff. Staff took time to consult with people and were skilled at providing information in a way that each person could understand and respond to. For example, we saw staff communicate with people about what they were going to do for the day and support them to make decisions and choices.

People's care records we looked at showed how they wished to be cared for. Their individual choices, preferences and aspirations were recorded and used to inform their care. Wherever possible, relatives had been involved in developing people's care plans. Staff we spoke with knew how people liked to be supported and their preferences. For example, we observed one person became distressed after their meal. We saw that staff responded in a discreet and sensitive way, providing reassurance and comfort in line with the person's care plan. Another person liked to spend time on their own watching their choice of television. We saw staff remind the person of additional lounges that they could use without interruption.

Staff demonstrated that they understood the importance of respecting and promoting people's privacy and dignity and took care when they supported people. One staff member told us, "I am professional when I support people. I always ensure I give people choices, for example, when they want to get up. I am also aware of my responsibility to encourage them to look after themselves as much as possible." During our inspection we observed that staff attended discreetly to people's on-going personal care needs to help ensure they remained clean and comfortable. For example, people were supported to preserve their clothing during mealtimes through being offered aprons where appropriate. People's bedrooms were respected as their own space and we saw that staff always knocked and did not enter until asked to do so.

People were supported to be as independent as possible through an individual programme of rehabilitation. This included daily living skills, such as maintaining their bedroom and belongings and staff providing the right level of support to encourage people to develop their physical and emotional independence.

Good

Is the service responsive?

Our findings

People told us they were encouraged to make decisions about how they spent their time. For example, one person had arranged to spend time in the gym on the morning of our inspection visit. We saw the person had decided to get up later that day and was just beginning breakfast at the time of their gym session. The staff member consulted with the person who made the decision to have their session at a later time that day. People could choose to spend time in one of the communal lounges, their own room or one of the therapy rooms.

People had a detailed assessment of their needs when they moved to the service. Assessments included key information about people's medical background and health conditions in addition to information about the person's likes, dislikes, abilities and preferences. Assessments involved a range of health professionals, including hospitals and social workers. Wherever possible, the person and, where appropriate, relatives were involved and consulted during the assessment and development of the care plan. The information from the assessments was used to develop the care plan and rehabilitation programme which was individual to each person. An example was for a person who liked to play football but was no longer able to walk due to their health condition. As part of the person's rehabilitation, staff explained that the person was able to use a specific hoist in the gym that supported them to achieve a standing position and participate in a football knock about. Another person was supported to access the outreach support the service provided. The outreach service providing on-going support and rehabilitation to people who had moved back to their home and visited the service for a few hours each week. The service recognised the person's cultural needs and provided care and treatment that was flexible to their specific needs and wishes. This showed that staff provided care that was responsive to people's individual needs and preferences.

People's care plans included information about their preferences, for example, what time they liked to get up and whether they preferred a bath or shower and when. Care plans included guidance as to people's abilities, what areas they needed support in and what the support should look like. Care plans also included details of people's neurological conditions and how this may affect their communication and ability to understand and process information. Staff demonstrated that they understood people's care plans and how each person liked their care to be provided. For example, one person was known to demonstrate anti-social behaviours if they ran out of an item they needed. Staff worked with the person to ensure they had the item in stock and reduced the risk of the behaviour that could challenge. Staff told us they had read people's care plans and that the registered manager was always helpful if anything needed explaining or advice was needed. This meant people received care that was personalised and met their needs.

People's care plans were reviewed on a regular basis through internal meetings involving a range of health professionals and the registered manager. People, and where appropriate their relatives, were able to share their views about their care as part of this process. Records showed people's views had been considered and included where changes to people's care had been made. This showed the service was responsive to changes in people's needs and wishes.

People were offered a range of therapeutic activities as part of their rehabilitation. We saw people were

supported to engage in activities including games, current affairs and using the gym. We observed a staff member supporting two people to play a connection game. The staff member supported each person to understand the game and what they needed to do to beat their opponent. Both people were engaged in the session and told us they enjoyed what they were doing. Another person was supported to understand current affairs of the day. We saw a staff member sit with the person and use a newspaper as a means to orientate the person to the date, season and key events. The staff member was able to engage the person in discussions about the weather, time of year, and key events in the world. The person participated in discussions and told us they enjoyed spending time one-to-one with staff. Other people were engaged in activities such as word searches and cross words.

Throughout our inspection visit we saw people spending time with the physiotherapist in the gym, using equipment and undertaking exercises to assist in their physical well-being. Staff told us that, where appropriate, people were supported to access the local community and spend time with their family and friends as part of their care. This meant people had access to meaningful activities which reduced the risk of social isolation and boredom.

The provider had a procedure in place about how to make complaints, a copy of which was clearly displayed in reception and available to all visitors. At the time of our inspection visit, no complaints had been received at the service. Where people had expressed concerns, we saw the registered manager had listened to people, investigated their concerns and provided a response to the person. For example, where one person had made allegations about their care during the night, we saw the registered manager had responded appropriately to investigate their concerns and put in place measures to reassure the person. The registered manager told us that advocates were available to support people in the event they had concerns or wished to make a complaint. This meant that people could be confident that their concerns would be listened to and acted upon.

Good

Is the service well-led?

Our findings

People spoke positively about the service. One person told us the service was really good and had done great things for them. Another person told us the service was "Very good." Another person gave the service the thumbs up when we asked them what they thought of it.

Staff we spoke with praised the organisation and leadership of the registered manager. Their comments included, "This service is well-led. We get all the information we need. [Name of registered manager] listens to us and supports us, " and "Everything is open and professional here. She [name of registered manager] is on you in a heartbeat if things are not done the right way but is also approachable," and "She [name of registered manager] is a lovely lady. I can go to her anytime, she makes the staff feel supported."

The registered manager provided clear and confident leadership for the service and had worked to embed a culture that was reflective of the values of the organisation. We saw that the registered manager was available to speak with people, staff and visitors throughout the day. Staff meetings were held regularly. We looked at the minutes of recent staff meetings and saw these were well attended. Staff were supported to identify and discuss improvements in working practices including best practice, information about people currently using the service and new admissions was shared and updates provided regarding people under DoLS authorisations. The registered manager told us that training sessions were also undertaken after staff meetings, for example, in the completion of recordings, to develop staff knowledge and awareness as a team. This enabled staff to share their views and contribute to improvements within the service.

People and, where appropriate, their relatives were able to share their views through a variety of forums. This included weekly reviews of their care, meetings with a range of health professionals, through the advocacy service and through a suggestions box which invited people and visitors to submit any suggestions on the service, including areas for improvement. This supported people to share their views of the service using their preferred method of communication and influence how it was run.

The registered manager was in day-to-day control of the service and had a personal knowledge about the people the service was supporting and each member of staff. They were clear on their legal responsibilities included what was expected of them regarding their legal obligation to notify us about certain events.

Checks and audits were made by the registered manager and senior staff in areas such as health and safety, accidents and incidents infection control, care and staffing. We saw that audits were collected into a quality report which helped the registered manager to identify any trends or patterns and areas that required further development. The clinical lead was in the process of developing a new system for the auditing of medicines and would ensure this was robust once in place. This would help to reduce the risk of errors and ensure people received their medicines safely.

The registered manager understood the key risks and challenges facing the service. They told us about the improvements they were making to the way care was provided at the service to meet a demand for longer-term care for people with neurological conditions. At the time of our inspection, the service was undergoing

building work to develop an old part of the building and create accommodation specifically for people who required longer-term placements within the service. We saw the registered manger had ensured rooms and areas were designed to support people with complex health conditions who were likely to move into the service. This showed that the registered manager was responsive to changes and demands within the health and social care sector.