Carrington House Ltd

# Carrington House Limited

## Inspection report

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Tel: 01525853211

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13 October 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place on 12 and 13 October 2017.

At the last inspection in October 2016, we asked the provider to take action to make improvements to the cleanliness and safety of the service; staff deployment; quality of people's care records; how people's medicines were managed; quality of staff training records; and how they assessed and monitored the quality of the service. During this inspection, we checked if improvements had been made and we found they now met the regulations.

Carrington House provides care and support to people with a range of care needs including those with chronic health conditions, physical disabilities, dementia, and mental health conditions. At the time of the inspection, 59 people were being supported by the service and one person was on trial leave before moving to a Supported Living Service.

There was a registered manager in post. 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.

People were safe because the provider had effective systems to keep them safe, and staff had been trained on how to safeguard people. There were individual risk assessments that gave guidance to staff on how risks to people could be minimised. People's medicines were managed safely and accurate records were now kept. The provider had effective recruitment processes in place and there was sufficient numbers of staff to support people safely. The service was now clean and safe for people to live in.

Staff received effective training, support and supervision that enabled them to provide appropriate care to people who used the service. The requirements of the Mental Capacity Act 2005 were now being met because people's ability to make decisions about their care and support was appropriately assessed. People were supported to have enough to eat and drink, and they now had their meals quickly. They had access to various health services when required.

Staff were kind and caring towards people they supported. They treated people with respect and as much as possible, they supported people to maintain their independence. People were happy with how their care was provided and they valued staff's support. People made decisions and choices about how they wanted to be supported and staff respected this.

People's needs had been assessed and they had care plans that took account of their individual needs and preferences. Care plans now contained personalised information that enabled staff to provide person-centred care. Staff were responsive to people's needs and where required, they sought appropriate support from healthcare professionals. The provider had an effective system to manage people's complaints and

concerns.

There was stable leadership of the service because the registered manager now only managed this service. Staff felt well supported and their contributions recognised. The provider had made significant improvements to all areas where we had previously identified shortfalls. On-going audits were also carried out. However, improvements were required in the quality of staff recruitment records. Further work was needed to improve people and relatives' experiences of the service.

## 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 felt safe with how staff supported them and there were effective systems in place to safeguard them.

There was enough skilled and experienced staff to support people safely and quickly.

People's medicines were now managed safely.

### Is the service effective?

Good

The service was effective.

There was now evidence that staff received regular training, supervision and support in order to develop and maintain their skills and knowledge.

The requirements of the Mental Capacity Act 2005 were now being met.

Staff understood people's individual needs and provided effective support.

People had been supported to eat well and to maintain their health and wellbeing.

### Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and friendly.

Staff respected people's choices and supported them to maintain their independence.

People were supported in a respectful manner that promoted their privacy and dignity.

### Is the service responsive?

Good

The service was responsive.

People's care plans were now personalised to enable staff to provide person-centred care.

People's needs were met in a timely way by responsive and attentive staff.

The provider had a system to manage people's complaints and concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Improvements were required to the quality of staff recruitment records. Further work was also needed to improve people and relatives' experiences of the service.

The registered manager provided stable leadership because they now only managed this service.

Significant improvements had been made to all areas where we had previously identified shortfalls. On-going audits were also carried out.

# Carrington House Limited

**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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all key questions to at least good. They sent us a satisfactory action plan showing that they had put more robust processes in place to make and sustain the required improvements. We followed up on this during this inspection.

This inspection took place on 12 and 13 October 2017, and it was unannounced. The inspection was carried out by two inspectors 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this and other information we held about the service including the report of our previous inspection and notifications they had sent us. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with eight people who used the service, six relatives, four care staff, an activities coordinator, medication coordinator, and a cook. We also spoke with the registered manager and the administrator who was being trained to take on the role of deputy manager. We observed how care was provided in communal areas of the service.

We looked at the care records for 10 people who used the service. We also looked at recruitment and supervision records for five care staff, and the training records for all staff employed by the service. We reviewed information on how medicines and complaints were being managed, and how the quality of the service was assessed and monitored.

We contacted professionals from the main local authority that commissioned the service and we received positive feedback about the outcome of their inspection of the service in August 2017, when they gave the service an overall rating of 'good'.

Good

# Is the service safe?

## Our findings

When we inspected the service in October 2016, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate standards of cleanliness and safety had not been maintained. They were also in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's medicines were not always being managed safely. Additionally, staff were not always deployed appropriately, resulting in delays in people being served their meals at lunchtime.

During this inspection we found improvements had been made and people now lived in a clean and safe service, their medicines were managed safely, and they were supported quickly to have their meals.

People told us that they felt safe living at the service and they were supported well by staff. One person said, "There's usually someone around to help." One relative told us, "[Relative] is safe here, 100% safe." Another relative said, "[Relative] is safe here."

The provider's safeguarding and whistleblowing processes were effective in protecting people from potential harm and abuse. Whistleblowing is a way in which staff can report concerns within their workplace without fear of consequences of doing so. Staff had been trained on how to safeguard people. They understood what constituted abuse and described the reporting procedures. Staff told us that they had never been concerned that people might be at risk of abuse within the service including one member of staff who said, "I have never reported abuse." However, they all said that they would report to the registered manager if they were ever concerned about a person's safety. They also knew who to contact outside of the service if required. We noted that the registered manager had appropriately reported potential safeguarding issues to relevant organisations.

The registered manager reviewed incidents that occurred within the service and there were risk management systems in place to ensure that risks to people could be appropriately managed and mitigated. Care records showed that people had individual risk assessments including those for risks associated with people being supported to move, falling, eating and drinking, pressure damage to the skin, use of bedrails, behaviours that may challenge others, and specific health conditions. We noted that the risk assessments were reviewed monthly or updated when people's needs changed, and where necessary, appropriate preventative care was put in place. For example, one relative told us about how staff made sure the environment was free from hazards so that their relative's risk of falling was reduced. They said, "[Relative] was beginning to have a lot of falls and they did everything they could to reduce this. They moved furniture around, put in crash mats and sensor mats and the falls were very much reduced."

Care was now provided in a safe environment because regular health and safety checks were completed to ensure the service was free from hazards that could cause harm to people who used the service, staff and visitors. Additionally, regular checking of gas and electrical appliance, fire alarms, fire-fighting equipment, and emergency lighting reduced the risk of a fire causing harm to people. Monthly fire drills also took place to ensure that staff knew how to support people safely in the event of a fire or another emergency that

required the service to be evacuated. A relative told us that staff supervision and robust external doors meant that the risk of their relative leaving the service unsupported was low. They said, "It is good that [relative] cannot escape which was a big worry for me."

We saw that all broken equipment and furniture identified during our previous inspection had been either thrown away or replaced, communal areas had been de-cluttered and equipment was now stored in places where they did not present a trip hazard.

We also saw that standards of cleanliness had significantly improved and the service was visibly clean and smelt pleasant. The registered manager told us of the refurbishment work that had been done to improve the environment people lived in. This included deep cleaning of carpets, steam cleaning bathrooms, and work to replace carpets in bedrooms with vinyl flooring that could be easily cleaned was still in progress. It was because this could only be done when there were empty bedrooms to temporarily move people to. We saw that the number of cleaning staff had been increased and the service was now being cleaned to appropriate standards. Cleaning staff took prompt action to clear any spillages that could cause people to slip and fall. Appropriate signage was also used to alert people when an area of the floor was wet.

We looked at recruitment records for five members of staff. We found the registered manager completed the required pre-employment checks including confirming each member of staff's identity, employment history, qualifications and experience, obtaining references from previous employers and completing Disclosure and Barring Service (DBS) checks. Although some of the records did not clearly show that appropriate processes had been followed to ensure that staff were safe to work at the service, we judged that at present, this omission did not put people at risk of harm. We discussed this with manager who acknowledged that they needed to improve their record keeping processes.

People and relatives told us that staff were always busy, but that they supported them safely. One person said, "The staff are very busy all the time, lovely but busy." One relative told us, "The staff are very busy, not much time, always rushing." Another relative told us that although the service mainly had enough staff, there had been times when they had been short staffed. They said, "When they are fully staffed there are enough, but sometimes they struggle a lot and are understaffed." Staff told us that there were normally enough of them to support people safely, apart from occasions when they had not been able to cover for sickness at short notice. One member of staff said, "There are between nine and ten care staff on each shift, and a minimum of 2 senior staff. It's enough and staffing is consistent." Another member of staff said, "There are enough staff." We noted that enough numbers of staff were always planned to support people quickly and safely. Our observations during the two days of the inspection showed that people were supported in a professional, friendly and unhurried manner.

People's medicines were now being managed safely and people told us that they were happy with how they were supported with their medicines. This was because the provider had improved their processes for ordering, recording, auditing and returning unrequired medicines to the pharmacy. There was a 'medication coordinator', a dedicated member of staff responsible for ensuring that medicines were managed safely within the service. We discussed with them what their role was and they told us that they ordered medicines to ensure that they kept appropriate stock levels, audited medicines administration records (MAR) to ensure that these were completed fully, and liaised with GPs and the pharmacist to ensure that prescriptions were processed in a timely way. They also organised in-house training for staff provided by a pharmacist, and completed competence checks to ensure that staff administered people's medicines safely.

We looked at all the MAR for the previous cycle ending on 3 October 2017 and found that there had been improvements in how these were maintained. We noted that they had all been completed fully, with no

unexplained gaps. We also found no gaps in some of the current MAR we looked at. One of the staff who administered medicines told us that this was managed well and were complimentary about the role of the 'medication coordinator' in ensuring that people always had their medicines.

Good

# Is the service effective?

## Our findings

When we inspected the service in October 2016, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because people's capacity to make and understand the implication of decisions about their care was not consistently assessed or documented within their care records. This did not always meet the requirements of the Mental Capacity Act 2005 (MCA). There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because training records did not evidence that staff had always been appropriately trained. There was also a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had to wait a long time to be supported to eat their meals.

During this inspection, we found improvements had been made. The requirements of the MCA were now being met as there were mental capacity assessments that identified specific issues that people were assessed for and these had been recorded in people's electronic records. 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.

Staff demonstrated an awareness of their responsibilities under the MCA. They spoke clearly about how they supported people whose capacity fluctuated and about people's right to make their own choices. They also told us that they obtained verbal consent prior to them providing care and support to people. One member of staff told us, "We always assume people have capacity and if they do, we respect their right to make choices even if they are unwise."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that where required, the registered manager had made referrals to relevant local authorities to ensure that any restrictive care was lawful. A relative told us that they were happy that their relative had a DoLS authorisation in place to prevent them from leaving the service unsupported, as they would be at risk of harm if they did so.

People and relatives were happy with how staff supported people, and they also said that staff had the right skills to support them effectively. One person said, "They help me here." Another person said, "They know what they are doing." A relative told us, "They look after [relative] well." This was supported by a member of staff who said, "People are well looked after." Another member of staff said, "People get good care. Residents are put first and it's a great environment."

Although training records showed that some of the staff were now overdue their refresher training, the registered manager had made plans for staff to complete this as soon as possible. Staff told us that they provided appropriate and good quality care to people because they had received appropriate training for

their roles. They also commented that the training was of a high standard, including one member of staff who said, "I would rate the training nine out of ten, one of the best I have had." Another member of staff said, "It's a mix of on-line and practical. It's good quality." A third member of staff told us, "The training is very helpful. It's relevant." They further told us of additional training that staff could do in order to meet people's individual needs. They said, "Training on PEG feeding was really good." They said that this had enabled them to provide effective care to a person with a Percutaneous Endoscopic gastrostomy (PEG), a tube passed through the person's abdominal wall to enable them to take food and medicines as oral intake was no longer possible.

Staff told us that they received regular supervisions and annual appraisals which they found helpful. They also said they felt supported by senior staff. One member of staff said, "I am supervised by [manager] monthly. There is also an annual appraisal." Another member of staff commented, "Monthly supervision is useful. I feel really well supported. You can ask the manager or director anything." Another member of staff said, "I am well supported. You can ask anyone for help."

Everyone we spoke with told us that the food was satisfactory and that there was a choice of different foods at each mealtime. One person told us, "Food is okay, they are cooking for a lot of people." A relative said, "The food is alright, but I bring in treats." People told us alternative food was provided if they did not like what was on the menu and we observed this during the inspection when a person was given a prawn cocktail salad because they did not like their meat dish. However, they did not seem to have much appetite as they only ate half of their meal. One person also told us, "If you don't like it, they will give you something else usually."

We saw that people with specific dietary needs were also supported to eat well to maintain their health and wellbeing. The cook showed us that they had a list of people's food preferences and a list which provided information about people with special dietary requirements. One relative we spoke with confirmed that their relative was given food in a way that met their individual needs. They said, "[Relative] has blended food, but doesn't eat much now." The cook further told us, "At present, there are no vegetarians, people on gluten free, and there are no cultural diets to cater for."

We observed that people's meals were served quickly and they did not sit at the dining tables for a long time before they were given their food or supported to eat. Also, food for people who required staff support to eat was brought only when a member of staff was available to support them so that it did not get cold. We observed a number of people being supported to eat during the first day of the inspection and this had been done in a respectful and dignified way, as staff ensured that they gave people mouthfuls of food at a pace appropriate for that person. They also spoke with people during this, occasionally asking if they still wanted more of their food.

Staff we spoke with had no concerns about people not eating or drinking enough, and we saw that in addition to formal mealtimes, snacks and drinks were also provided regularly. We observed that staff were good at prompting people to have a drink. People's weight was monitored monthly and appropriate action taken if they were noted to be losing weight.
The service had maintained high levels of food management standards and in June this year, they achieved the maximum food hygiene rating of 5. They also had a 'Food First' accreditation. Food First is a programme run by the NHS dietetics service to help care providers manage nutrition and hydration for older people in care homes and in the community.

People and relatives told us that people were supported to access health services such as GPs, chiropodists, opticians or to attend hospital appointments. One relative said, "The doctor comes in every Monday. He will

always feed back to us." Relatives also told us that staff acted appropriately when people required urgent care and they were always informed when people needed to go to hospital. One relative said, "[Relative] was rushed to hospital and they called me straight away." Another relative said, "[Relative] has been in hospital a few times and they always tell us immediately. They are good at letting me know if there is a problem and they explain things like changes in medication." We found the provider worked collaboratively with other professionals to ensure that people had the care and treatment they required in a timely way. One person had a hospital appointment on the first day of our inspection and arrangements had been made for them to attend this on time.

Good

# Is the service caring?

## Our findings

When we inspected the service in October 2016, we found people's care plans were not personalised enough to enable staff to understand people's individual personalities, life experiences and interests.

During this inspection, we found care records now contained personalised information that enabled staff to know people they supported well. Where detailed information about people's lives prior to moving to the service could be obtained from people or their relatives, we saw that some people's care records contained a document called 'Who am I'. This detailed information about people's family history, medical history, known allergies, any disabilities that would affect the way staff communicated with them, and support needs.

Staff demonstrated that they knew people well. For example during lunch, a member of staff explained that a person only ate a little lunch, but liked to eat with their relative who visited most afternoons. We also observed that staff interacted positively with people, sometimes referring to what music people liked and their memories of listening to that type of music when they were younger. Also, staff were observed to respond kindly and calmly to a person when they became tearful. We also saw that staff were excited for a person who had received news that they could now take food orally again following some medical investigations.

People and relatives were complimentary about how caring staff were. One person told us, "They are lovely." Another person said, "They are very kind."

Although some people told us that staff were always busy, we noted that staff had time to chat with people every time they came into one of the communal lounges. We observed that interactions between staff and people were inclusive and respectful, as staff tried to also engage with people who would not normally initiate a conversation. One member of staff described how they were caring in their approach, particularly when supporting people who could be isolated in their bedrooms. They said, "A few people are bed bound. We ensure they are kept stimulated, for example with the TV and radio. There is also time for people to have a one to one chat."

Staff appeared to have formed good and caring relationships with people and relatives who regularly visited the service. The provider supported people to maintain close relationships with their relatives. Relatives told us that they could visit their relatives whenever they wanted and they always felt welcomed. One relative said, "I can come when I want to and I can stay as long as I like." Another relative told us, "I have been here in the middle of the night when we've come back from the hospital, to settle [relative] in and there is never a problem with coming in and out. I can come and go as I wish."

People told us that they and their relatives were involved in planning their care. They also said that they made decisions and choices about how they wanted to be supported and live their lives, and staff respected this. One person told us that they were able to decide when they went to bed or woke up in the morning. They said, "I can get up and go to bed pretty much when I want to." Another person told us, "I go to bed

when I'm ready or I when I want to have a rest." Another person told us that they preferred spending most of their time in their bedroom and staff respected their choice to do so.

People told us that staff respected and promoted their privacy and dignity, particularly when supporting them with personal care. One person said, "They are very good, they always make sure my door is closed if I need help." Another person told us that staff always supported them promptly if they needed help with their personal care and that this maintained their dignity. They said, "They never make a big fuss, they just do it." This was supported by a relative who told us, "I tell them when [relative] needs help and they do something straight away."

Staff told us that they supported people to maintain their independence by giving them opportunities to do as much as they could for themselves. We noted that staff also understood how to maintain confidentiality by not discussing about people's care outside of work or with anyone not directly involved in their care. We also saw that people's care records were kept securely within the service to ensure that they could only be accessed by people authorised to do so.

People had been given information about the service in order for them to make informed choices and decisions about whether they wanted to live there. Information available to people and their relatives included what the service did and how they would meet people's individual needs, where they could find other information, such as the complaints procedure. Some of the people's relatives or social workers acted as their advocates to ensure that they understood the information given to them and that they received appropriate care. There was also information about an independent advocacy service that could support people to better understand their care plans and express their wishes.

Good

# Is the service responsive?

## Our findings

When we inspected the service in October 2016, we found people's care plans were not personalised enough to enable staff to provide person-centred care to people who used the service.

At this inspection, we found improvements had been made so that people received appropriate care that met their needs and expectations. People told us that their individual needs were met by the service and they were happy with how staff supported them. Assessments of people's needs had been carried out prior to them moving to the service and this information was used to develop their care plans. People and their representatives' views had also been sought during the assessment process and as much as possible, they were involved in planning and reviewing the on-going care and support provided by the service. This ensured that the care plans took account of people's preferences, wishes and choices.

We saw that people's care plans identified their care and support needs in various areas including communication, nutrition, mobility, personal care, medicines, social interests and hobbies; religion. For example, one person's care plan for eating and drinking explained that the person sometimes opted for a soft diet and sometimes preferred finger food. This information was also held by the cook and their risk assessment showed that their nutritional needs were monitored and they were supported by a dietician. In addition, their food and fluid charts were up to date and appropriately completed. Care plans remained relevant to people's needs because they were reviewed by staff on a monthly basis or earlier if there were significant changes in people's care needs. One member of staff told us, "Care plans are kept up to date. Staff report changes to the office and they update care plans. Staff keep daily notes up to date on the computer."

Daily records were also well maintained and up to date. For example, on the first day of the inspection staff had been told at handover about a person with a suspected urine infection, the doctor had been called and visited the person during the morning and this had been recorded when we checked the daily records during early afternoon. Staff told us that the electronic records meant that they could update care records as soon as possible after providing the care, and this was then available for other staff to see before supporting the person again later. This supported them to provide continuity of care and to always respond appropriately to people's needs.

Although some people and relatives said that there was not always enough activities provided to entertain people or to support them to pursue their hobbies and interests, we saw that a varied programme of activities was planned. Some of the comments included one person who said, "I like to do things. Sometimes there is something, but we did used to do a bit more." Another person said, "I just stay here, there's not much to do." A third person said, "There's hardly anything to do most days, but they are nice here so that makes a bit of a difference."

We saw that two activities coordinators were employed, although one was on leave during the inspection. The activities coordinator we spoke with told us that although they had activities planned for each day, they were flexible in what was actually provided depending on what people wanted to do. They also told us that

they were normally able to provide a lot of activities when they were both working and that it was not always possible to provide something in all the lounges when one of them was available. They commented, "There is a weekly and monthly planner, but it does change. When there are two of us, there is plenty going on. We do something in all of the lounges." They further told us how they engaged with people normally supported in their bedrooms. They said, "There is 'butterfly time' between nine and ten am. We have a chat with everyone who is in their room and tell them what is on TV. We read to [person]. There is enough time for each person to have 10 to 15 minutes." However, we noted that not many people were fully engaged in a quiz arranged by the activities coordinator.

Staff told us that there was normally enough planned to support people to appropriately occupy their time. One member of staff said, "There is enough going on for people. There is often Sky Sports for the gentlemen in lounge 1. The hairdresser comes twice a week. There is a regular DJ and chair exercises." Another member of staff said, "People are settled and there is enough going on." We noted that the hairdresser was at the service on the first day of the inspection and we spoke with some people who were either looking forward to their hair being done or were happy with how it looked after it had been done.

The provider had a system to manage complaints raised by people, their relatives or other professionals. Most people told us that they had not complained because they were happy with how their care was managed. They also said that they could speak to both staff and the registered manager if they had any concerns. One person said, "I've not had to complain, we've never had any issues." One relative said, "Everything is ok, no problems." Those who had complained said that their concerns were acted on and improvements made. We noted that the provider had received three complaints since January 2017 and we saw that the registered manager had taken appropriate action to investigate these and respond to the complainants in a timely way.

Requires Improvement

# Is the service well-led?

## Our findings

When we inspected the service in October 2016, the provider was in breach of a number of regulations including Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they did not have robust quality monitoring processes to assess and monitor the quality of the service. They had neither identified the shortfalls we identified during the inspection nor acted promptly to make the required improvements when concerns had been raised. The registered manager was not able to carry out their role fully because they also managed another of the provider's care homes. Additionally, people's confidentiality was not protected because their care records were not always appropriately stored.

During this inspection, we found improvements had been made and the service benefitted from stable leadership as the registered manager was now only managing this service. We spoke at length with the registered manager who told us this change had been positive in that it allowed them the time to make the changes necessary to improve the quality of the service. This meant that they were able to review people's care records to ensure that they were personalised and contained information required for staff to provide safe, effective and person-centred care. They worked with the 'medication coordinator' to ensure that robust systems were in place to enable staff to manage people's medicines safely and keep accurate records. The registered manager also told us how they had worked with the provider to ensure that financial resources were available to make the required improvements to the physical environment. This allowed them to replace broken furniture and equipment, and we saw that this had resulted in significant improvements that meant that people now lived in a safe and pleasant home. The registered manager and other senior staff also continued to carry out regular audits to ensure that the improvements made could be sustained.

However, we found the registered manager needed to improve the quality of staff's recruitment records to evidence that appropriate processes had been followed. For example, when staff came to the service with a Disclosure and Barring Service (DBS) report less than three months old, this was used before the provider applied for one. However, there was not always a copy of this in the staff files leading to information showing that staff started work before the provider requested a DBS. For one member of staff, there was also no evidence that further attempts had been made to get a professional reference before one was requested from their relative. Some of the people and relative's perceptions were that staff were always too busy to engage socially with people and that there was not enough activities provided needed to be addressed by the provider to ensure that people's level of satisfaction with the service was high.

People and relatives told us that they had not been given much opportunity to provide feedback. One relative told us, "We've just had the first relatives meeting announced. We haven't had any before that." Another relative said, "This is the first relatives meeting I have noticed." The registered manager told us that they had not held a relatives' meeting for a while because most of them did not attend. However, they had decided to trial this again and a notice was displayed telling visiting relatives about a planned meeting on 18 November 2017. The registered manager was also going to communicate this by email to ensure that everyone knew about it. They told us that due to people's complex needs, it was not possible to facilitate

group meetings and they had started getting feedback from people by speaking with them individually. We saw records confirming this and a questionnaire had been used to ask people about a number of issues including: the choice of food and their mealtime experiences; activities; décor of the service; staffing levels. The registered manager told us that they intended to speak with 10 people each month which meant that each person would have an opportunity to provide formal feedback twice a year. We also saw that the cook asked a number of people what they would want added to the menus in April, May, July and August 2017. We noted that people's suggestions were considered and where these were not already on the menus, they were added or an effort made to supply this for individual people. This showed that people's feedback was acted on and appropriately used to improve their experience of the service.

People and relatives we spoke with said that the registered manager was friendly and approachable. One person said, "The manager is fine." One relative said, "I don't know the manager very well, but she is approachable and professional." Staff were also complimentary about how the service was managed, and they found the manager and other senior staff approachable and very supportive. They felt valued, listened to and encouraged to contribute to the development of the service. For example, one member of staff told us that they had asked for an additional computer at a recent staff meeting and this had been provided quickly. This enabled them to write in people's care records as soon as they had provided care and support. Staff told us that the registered manager promoted a caring and inclusive culture within the service, and that they worked within these values. They said that they worked well as a team and supported each other. One member of senior staff told us, "I try to create a positive culture and encourage other staff to talk to me about issues or when they feel under stress."

We saw that regular staff meetings took place to enable staff to discuss issues relevant to their work. Staff found these meetings informative. One member of staff said, "Staff meetings are every three months or as required." Staff also told us that they used handover meetings effectively to share important information that enabled them to appropriately plan people's care.