Care Quality Commission

Community Integrated Care

Community Integrated Care (CIC) - 4 Seafarers Walk

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 18 and 19 May 2015 and was unannounced.

4 Seafarers Walk is situated in a quiet residential area to the south east of Hayling Island. The home is a bungalow which was purpose built to provide accommodation and care to five people with learning and physical disabilities. At the time of this inspection there were four people living in the service.

There was no registered manager in post at the time of the inspection, however there was a service lead in post who was responsible for the day to day running of the service and was applying to become the registered manager. The service had not had a registered manager for more than six months. 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, happy and comfortable when being supported by staff. Relatives felt people were safe, treated

Summary of findings

as individuals and were encouraged to raise concerns about their relatives care. Staff had received training in safeguarding adults and knew how to keep people safe from harm and would report any concerns to the service lead. Systems were in place to ensure people's money had been managed safely. Safeguarding concerns were raised and reported by management to the local authority and the Care Quality Commission (CQC) had been notified of these concerns.

Risk assessments were completed for each person which identified risks to themselves and others. Risk management plans were implemented to ensure people and those around them were supported to stay safe. Staff were trained in the Management of Actual or Potential Aggression (MAPA). This enabled staff to safely disengage from situations that presented risks to themselves, the person or others without the use of restraint. Premises and equipment were managed to keep people safe.

There were enough staff to meet people's needs and for them to be supported in the community to access activities or healthcare appointments. Safe recruitment practices were followed. There were clear procedures for supporting people with their medicines safely

Positive comments were received from relatives about people's care. One relative told us what they liked about the service was the knowledge the staff had of their relative. Staff demonstrated a good understanding of people's support needs, behaviours and likes and dislikes.

Staff received an induction when joining the home, had received regular supervision, felt supported and could request any additional training that would help them meet the needs of people. A training plan was in place and on the day of the inspection training courses were being booked for staff to attend and update their knowledge and skills.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the service lead understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Where people lacked the mental capacity to make decisions the home was mostly guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. Mental capacity assessments were not updated in line with the MCA code of practice. We have made a recommendation for the provider to read and address this in line with the MCA 2005 code of practice which refers to the reviewing of mental capacity assessments.

People were supported to have enough to eat and drink. People were given a choice and were involved in decisions about their meals. People who required a specialised diet were supported with this following referrals to the appropriate healthcare professionals. People regularly accessed healthcare services

People and their relatives were positive about the care and support received from staff. One relative said, "Everyone seems to be really warm and caring." There were positive and caring interactions between members of staff and people. Staff spoke to people in a kind and respectful manner and people responded well to this interaction by smiling and responding verbally using words or excited sounds.

People were encouraged to do as much for themselves as possible. We saw people answer the door whilst being supported by a member of staff and welcome visitors into their home. People were supported to do what they wanted to do and staff would use different communication methods to support people to make a choice. People's privacy and dignity was respected

People's needs were regularly assessed and reviewed by staff and they were involved in the assessment of their needs. Staff knew about the people they were supporting. People were able to communicate by speaking or making sounds and noises or by pointing to an object, person or picture and using body language. Communication books and handovers between shifts were used to communicate any information about each person for that day. Activities were personalised and people were supported to carry out the activities they enjoyed.

Relatives confirmed they had never needed to make a complaint about the service and felt confident to express

Summary of findings

concerns. The complaints procedure was displayed in the hallway of the home and an easy read summary including pictures was also displayed showing people how they could make a complaint about their care.

There was a clear vision and a set of values that involved putting people first and staff were aware of the vision and values of the service. The service lead had an open door policy and was approachable to staff. Staff confirmed this and said management were very good and very supportive. Staff were supported to question practice and they demonstrated an understanding of what to do if they felt their concerns were not being listened to by management.

The service lead had a good knowledge of people's needs and personalities. They demonstrated a good understanding of their role and responsibilities and were proactive in identifying development needs of the service.

There was a system in place to analyse, identify and learn from incidents, and safeguarding referrals. A number of audits had been completed to assess the quality of the home. A business continuity plan was in place to provide guidance for staff on how to continue to deliver a service in the event of an emergency.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff kept people safe from potential harm and treated them as individuals Relatives felt people were safe. Staff, people and their relatives were encouraged to raise any concerns about people's care.

Risk management plans were in place to manage any risks to people and staff demonstrated a good understanding of protecting people. There were enough staff to meet people's needs and safe recruitment practices were in place.

Safe practice for the administration, recording, checking, reporting and disposal of medicines was carried out.

Is the service effective?

Requires improvement

The service was not always effective.

Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 and its code of practice.

People were supported to make choices about how they wanted to live their lives**.** Staff knew people well and could demonstrate an understanding of people's needs and how they liked to be supported.

Staff were supported well and training was reviewed and updated.

People were supported to have access to healthcare services and were visited regularly by healthcare professionals to support them with eating and drinking.

Is the service caring?

Good

The service was caring. People and their relatives experienced care that was caring and compassionate and provided by staff who treated people as individuals and respected their privacy and dignity.

People were encouraged to do as much for themselves as possible. Staff offered sufficient choice for people to make a decision. Where necessary referrals were made to advocacy services.

Is the service responsive?

Good

The service was responsive. People received the care they needed, were listened to and had their rights respected. A variety of communication techniques were used to ensure people were engaged with and involved in making decisions about the support they wanted.

People's needs were regularly assessed and reviewed and they, their relatives and other health care professionals were involved in the reviews and assessment of their needs.

Summary of findings

Activities were personalised and people were supported to carry out the activities they enjoyed.

Is the service well-led?

Good

The service was well-led

There was no registered manager in post however a service lead had been appointed who was managing the service on a day to day basis and had applied to be the registered manager. There were a clear vision and values in place that staff were aware of and they put these into practice when supporting people. Staff confirmed management were good and they felt supported to raise any concerns about bad practice.

The service lead had good knowledge of people's needs and personalities and interacted well with them. They demonstrated a good understanding of their role and responsibilities and were proactive in identifying development needs of the service and putting them into place.

Quality audits were in place to ensure the on-going quality of the service was monitored.

Community Integrated Care (CIC) - 4 Seafarers Walk

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 18 and 19 May 2015 and was unannounced. The inspection team consisted of an inspector.

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 the Provider Information Record (PIR) and previous inspection reports before the inspection. We looked at notifications received by the provider. A notification is information about important events which the provider is required to tell us about by law.

On the day of the inspection we spoke with four people who lived at the home. The four people we spoke with were not always able to share with us their experiences of life at the home ,due to their particular communication skills therefore we also observed care practice to see how all four people interacted with staff. We spoke with three relatives, three support workers, one senior support worker and the service lead who was applying to become the registered manager.

We reviewed a range of records about people's care and how the service was managed which included the support plans for two people and specific records relating to people's health, choices and risk assessments. We looked at medicine records for two people, daily reports of support including staff handover communication notes, calendars showing what activities people liked to do and had planned to do, menus, incident and safeguarding logs, complaints and compliments, health and safety records and minutes of staff meetings. We looked at recruitment, supervision and training records for three members of staff and service quality audits.

We asked the service lead to send us information on their policies and procedures after the visit. We requested this information be sent to us by 21 May 2015, which was sent.

The last inspection of this home was in July 2013 where no concerns were identified.

Good

Is the service safe?

Our findings

People told us they were happy and we observed they were comfortable and happy when being supported by staff. Relatives felt people were safe, treated as individuals and were encouraged to raise concerns about their relatives' care. One relative said, "Yes safe, the staff know them well." Another told us they had raised concerns regarding their relative's support but felt listened to because the home looked into these concerns and were trying to make the changes that were required.

Staff said they would keep people safe from harm by reporting any concerns to the service lead. This included recognising unexplained bruising and marks or a change in behaviour. Staff had received training in safeguarding adults and had a good knowledge of the procedures they should follow if they had a concern. For example, one member of staff said, "Always be aware and if you see something or notice a change, keep an eye on the situation and report concerns to [service lead]." The process for reporting a safeguarding concern was displayed in the office and all four members of staff knew where to find this information.

Systems were in place to ensure that people's monies were managed safely. Mental capacity assessments had been completed for each person regarding their finances and the service lead told us the provider was the appointee for three people and for one person their relative was their appointee. An appointee is someone who has been formally chosen to manage monies on behalf of a person. People's money was kept in individual containers and in a locked safe. When people went out and took money with them it was counted out and back in to their individual container and checked each day by staff. We observed this practice being carried out.

Safeguarding concerns were raised and reported by management to the local authority and the Care Quality Commission (CQC) had been notified of these concerns. For example a recent incident had been reported by a member of staff to the service lead. An incident report had been completed, the Local Authority safeguarding team had been notified, CQC had received the appropriate notification and a performance improvement action plan had been put into place by the service lead. Management plans had been created following this incident to remind staff of the procedures when supporting people out in the community.

Risk assessments were completed for each person which identified risks to themselves and others. Risk management plans were implemented to ensure people and those around them were supported to stay safe. For example, one person's risk management plan identified the need to make the environment safe by removing any hazards that could harm the person or staff during the person experiencing a seizure. The risk management plan also identified how to support the person safely after the seizure had stopped. All staff knew how to support this person and confirmed what they needed to do to keep the person and themselves safe

Risk assessments were in place for people who experienced behaviours that could be seen as challenging. All staff knew the signs and triggers to look for when a person experienced such behaviours and were confident they could manage the situation without the use of restraint. For example, one staff member told us the different types of behaviours people could display and how they would manage to calm the situation by speaking calmly to the person, diverting their attention or asking if they wanted to go to a different room to relax or listen to music. The service leader confirmed restraint was not used in the service as staff were trained in the Management of Actual or Potential Aggression (MAPA). This training would enable staff to safely disengage from situations that present risks to themselves, the person or others without the use of restraint.

During our inspection we observed faulty equipment was being repaired and phonecalls were being made about other equipment that was requiring repair. The ceiling tracker hoist could not be repaired on the same day as a part was required. We saw signs had been placed on this piece of equipment to advise that it was not in working order. All staff had been made aware of this and the person who required the use of this hoist when bathing was informed they would need to use the shower room and the reason why. The ceiling tracker hoist and manual hoist had been recently serviced. All windows had openers attached to them to prevent them opening too wide and fire safety procedures were displayed in the hallway. Fire exits were clearly marked and the pathway was clear to access them.

Good

Is the service safe?

All fire equipment had been tested regularly and in line with the provider's policy. There was a staff member who was the designated lead responsible for ensuring fire safety procedures were carried out safely. This staff member was responsible for checking fire equipment regularly and ensuring all staff knew what to do in the event of a fire. For example, we saw a fire drill had been completed on 6 March 2015, the time was recorded for how long it took to evacuate the home and the number of staff and people evacuated. This meant the premises and equipment were managed to keep people safe.

Prior to the inspection we had received information of concern informing us that there were not enough staff to be able to support people effectively. At the inspection the service lead informed us staffing levels had been reviewed and an additional mid shift had been created to support people and ensure more activities could take place. As a result there were two support workers in the morning who were supported by an additional support worker mid morning. The service lead confirmed two support workers were on duty on the afternoon and evening shift and there was one support worker who worked overnight. Bank staff had been recruited by the provider to cover in times of absence or emergencies. The service lead confirmed all four people required one to one support in the home and out in the community. A system was in place to ensure all people's support hours were worked out and provided and the rotas were completed six weekly. The service lead told us there were some set activities built into the rota which were reflective of the personal interests of people and there was flexibility for people to be supported with daily activities.

Staff told us there were enough staff on shift as long as staff were not sick, however they confirmed bank staff had been recruited to cover for emergencies but that the majority of the time shifts were covered by permanent staff. Relatives we spoke with confirmed there were enough staff to meet people's needs however one relative said that an additional staff member would mean people would be able to do more activities. We saw there were enough staff to meet people's needs and for them to be supported in the community to access activities or health care appointments.

Safe recruitment practices were followed. We looked at three members of staff recruitment files and saw the appropriate steps had been taken to ensure staff were suitable to work with people. All necessary checks, such as Disclosure and Barring Service checks (DBS) and work references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were clear procedures for supporting people with their medicines. Relatives confirmed they did not have any concerns with how the home managed people's medicines. The medicines were kept in a locked cupboard in people's rooms and only staff that had been trained and confirmed as competent by the service lead were able to support people with their medicines. Staff members demonstrated a good understanding of safe storage, administration, management, recording and disposing of medicines.

Checks were completed daily by staff who were trained to support people with their medicines. Weekly and daily medicine audits were also completed by the management team which included checking for gaps in Medication Administration Record (MAR) sheets and any medicine errors. Two medicine errors had been identified by the management team and incident reports had been completed for both errors which detailed the reason for the error and what action had been taken to remedy them and prevent re-occurrence.

Requires improvement

Is the service effective?

Our findings

Relatives were positive about the support people received. One relative told us they were satisfied with the level of care their relative received and said, "[Person] seems to like the staff." Another relative told us what they liked about the service was the knowledge the staff had of their relative. Staff demonstrated a good understanding of people's support needs, and likes and dislikes.

Staff confirmed they received an induction when starting work at the home. This induction programme included shadowing an experienced member of staff to watch and learn communication techniques and understand people's needs. Staff would also read people's support plans and take part in corporate induction training. One staff member who had recently been recruited confirmed they were working towards their care certificate and Business and Technology Education Council (BTEC) qualification in health and social care.

Staff had received regular supervision from the service lead which gave them the opportunity to discuss people and identify additional support for themselves. Staff were delegated responsibilities in line with their job description and abilities. They were given the opportunity to feedback on their performance and personal development. Staff confirmed they felt supported and could request any additional training that would help them meet the needs of people. The service lead had a training plan in place and on the day of the inspection training courses were being booked for staff to attend and update their knowledge and skills, such as Management of Actual or Potential Aggression (MAPA), emergency first aid, moving and positioning and safeguarding.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how to put this into practice. The Act provides a legal framework for acting on behalf of people who lack capacity to make decisions. For example, staff confirmed that people could consent to most decisions concerning their day to day support by using communication techniques individual to the person to help them make a decision. Mental capacity assessments had been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing or finances. Best interests decisions had been carried out and appropriate professionals, advocates and relatives had been consulted. We saw mental capacity assessments had been completed for people to support them with finances and medicines, however these had not been reviewed since 2011. The service lead told us and demonstrated they were in the process of updating mental capacity assessments for all people living at the home because the mental capacity assessments had not been reviewed or updated for some time due to inconsistencies in management. **We recommend the provider follow the Mental Capacity Act 2005 codes of practice guidance on reviewing mental capacity assessments.**

We saw for two people a mental capacity assessment and best interests decision had been completed regarding the use of a lap strap on their wheelchairs when accessing the community for safety. We saw consideration had been given to whether the restriction was proportionate and the consequence of not having the restriction in place was highlighted. For example the person would be at increased risk of injury if the lap belt was not used. Consideration had been given to ensuring the restriction in place was not any more restrictive than was absolutely necessary as the mental capacity assessment and staff confirmed the lap belt was only to be used when the person was moving. This meant people were not restrained unlawfully and the provider followed the MCA 2005 and its code of practice.

People were supported to have enough to eat and drink. We observed people were given a choice of meal Relatives and staff confirmed they felt people were given a choice and were involved in decisions about their meals. For example, on the first day of our inspection we heard a member of staff asking a person what they wanted for breakfast. The person asked for Weetabix, which they were given. Drinks were offered and given regularly and fluid charts were present in the kitchen for staff to record and monitor the amount of fluids people were having each day. When people requested drinks they were supported with this.

Menus were in place for dinner time meals, such as fish or meat and people were supported to choose what vegetables they would like with their meal. People chose breakfast and lunch each day from a range of choices which were displayed on the board in the kitchen.

A menu folder was in place which included Picture Exchange Communication (PEC) symbols and pictures of

Requires improvement

Is the service effective?

food items to assist people to communicate clearly when choosing their meals. We saw a person had been supported to choose their lunch by pointing to pictures and making sounds.

People were supported well at mealtimes. Two people were on a specialised diet because they were at risk of choking. Staff were aware of the people who required support with eating and confirmed that advice and guidance from a speech and language therapist (SALT) had been sought. Staff told us the SALT advised for both people to have a fork mashable diet. We saw evidence of a referral to SALT had been made for these people and their support plans had been updated to include this information.

Staff and relatives confirmed people regularly accessed healthcare services and confirmed yearly check-ups with the GP and six monthly check-ups with the dentist took place. A person was being supported by a member of staff to attend a hospital appointment on our first day of inspection. Relatives confirmed they had been contacted and informed when an incident had occurred and their relative was at the hospital or waiting for a doctor to call at the home. The visitors log showed regular visits from healthcare professionals such as a chiropodist and occupational therapist.

Referrals had been made to other appropriate healthcare professionals when required such as learning disability nurses to update a person's epilepsy profile and a physiotherapist to provide a list of exercises to assist a person with a health related condition.

Good

Is the service caring?

Our findings

People and their relatives were positive about the care and support received from staff. One relative said, “Everyone seems to be really warm and caring.” When we asked people if they liked the staff who were supporting them they all smiled and one person said “Yes.” Other people made loud excitable sounds and would touch the member of staff indicating they liked them.

We observed positive and caring interactions between members of staff and people. Staff spoke to people in a kind and respectful manner and people responded well to this interaction by smiling and responding verbally using words or excited sounds. Staff members would bend down to the level of the person if they were sitting in an armchair or in their wheelchair and would make eye contact with the person. One relative told us they had been visting their relative at the home and the staff member was talking to them about the person with the person present. They told us the member of staff bent down to the level of the person and apologised for speaking about them to their relative in front of them. The relative felt this showed a lot of respect for the person.

People felt at ease and comfortable with members of staff and the service lead and would regularly visit the service lead in the office to help with photocopying or to communicate how they were feeling. For example one person came to the office and indicated they had a stomach pain by patting their stomach and making a groaning noise. The service lead stopped what they were doing, knelt down and spoke to the person and asked them if they were feeling unwell. The person responded positively and the service lead communicated in a kind manner how they would support the person to feel better.

People were encouraged to do as much for themselves as possible. We saw people answer the door whilst being supported by a member of staff and welcome visitors into their home. Staff said this was the person’s home and they were always asked if they would like to answer the door.

Staff confirmed they always asked people what they wanted to do and would use different communication methods to support people to make a choice. All the people in the home could communicate verbally either by speaking some words or making sounds. Pictures were also used as a communication tool to ensure people were given the support to clearly communicate their needs and wishes. For example, we observed a person taking their clothes to the laundry with a member of staff. We saw a person choosing the activities they wanted to do for the next day, another person went to their room to relax and listen to music and another person was watching their favourite TV programme in the lounge. Relatives confirmed people were always involved in their care planning particularly making decisions about what they wanted to do and wear on a day to day basis.

There was an effective system in place to request the support of an advocate to represent people’s views and wishes. Where necessary referrals were made to advocacy services. Advocates had been involved in best interests decisions for people. An advocate can help people express their needs and wishes, and weigh up and take decisions about the options available to them. They can help find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations. The advocate is there to represent people’s interests, which they can do by supporting people to speak, or by speaking on their behalf.

Staff confirmed they would respect people’s dignity and privacy by closing doors, knocking before entering the person’s room and informing them what they are going to do before supporting them with personal care or other support tasks. We heard staff knocking and asking if they could come in before entering a person’s room and staff closed doors when they were supporting people with personal care. People could access the home freely with or without support. Relatives felt staff respected their relative’s privacy and dignity and promoted their independence.

Good

Is the service responsive?

Our findings

People's needs were regularly assessed and reviewed by staff and people together.. Some relatives were more involved than others in the review of s their relative's needs however all confirmed they had been involved in sharing lots of information about their relative's past history to help the home with planning care for people.

Staff knew about the people they were supporting. Staff gave us examples of how they supported people differently according to their needs. For example, one person liked music and having manicures and another person liked cars and would be visiting Beaulieu national motor museum. All people needed different levels of support with their personal care and staff demonstrated a good understanding of these needs.

All people had individual support folders which contained support plans and risk assessments. The support plans were very detailed and included people's likes and dislikes, personal histories such as when their condition was diagnosed, communication needs, behaviour signs and triggers, personal care support, health plans and activities they enjoyed. The service lead and staff confirmed families and other professionals were involved in gathering information about people. Regular observations of people's behaviours and interactions were used to develop the support plans and risk assessments over time. Reviews of care plans were completed. The service lead told us they had implemented a key worker role to include weekly and monthly duties which included reviewing people's support plans. Staff we spoke with confirmed this had been discussed with them and they were aware of the responsibility of this role.

People were able to communicate by speaking or making sounds and noises or by pointing to an object, person or picture and using body language. Different communication techniques and tools were used with different people to encourage them to openly communicate their thoughts, feelings, likes and dislikes, choices and decisions. Communication books and handovers between shifts were used to communicate any information amongst staff about each person for that day, such as healthcare appointments, activities and additional requests for staff to review peoples' care plans and risk assessments.

Activities were personalised and people were supported to carry out the activities they enjoyed. The home had an activities board showing what activities people liked to do. The board had a picture of the person and pictures and words describing what activities each person enjoyed taking part in. For example, one person liked to go bowling and to the disco and another person liked puppy training and feeding the birds. Each person had an individual goal plan to support them with other activities around the home such as cleaning their room. Another activities board was present showing what activities the person had chosen to do that day. For example, one person was visiting their parents, one person was being supported to buy shoes, another person had been taken to a healthcare appointment and the fourth person had been supported i to go out for tea and cake. Activities also took place in the home and people were supported to listen to music, watch a television programme of their choice or help with their laundry.

Relatives confirmed they had never needed to make a complaint about the service.

Relatives felt confident to express concerns and if they had any issues they knew who to complain to and would be confident that the concern would be dealt with. One said, "I have not complained but I would imagine it would be dealt with." Another said, "I have been working with the service many years to try and resolve some issues I have with [relatives] care, however they listen and are trying to resolve them, but I need to develop trust." The service lead said they had not received any complaints since being in post but was aware and was working with one relative who had raised previous concerns by meeting with them regularly to update them on the person's support.

We saw the complaints procedure was displayed in the hallway of the home and an easy read summary including pictures was also displayed showing people how they could make a complaint about their care.

Good

Is the service well-led?

Our findings

There was not a registered manager at the home but a service lead was managing the home on a day to day basis and had submitted applications to register as the registered manager for the home. The service had been without a registered manager for more than six months, however the service lead was appointed in December 2014 and had submitted the applications to register as a a registered manager in December 2014.

There was a clear vision and a set of values that involved putting people first. The service lead told us that this was people's home and staff were aware that everything they did must include the person. They said, "Staff must make sure people answer the front door and feel that this is their home." The service lead also said that people can and did attend staff meetings, however people's needs would not be discussed in front of people due to respecting people's privacy and dignity. Staff were aware of the visions and values of the home and put these into practice when supporting people. We observed these values being put into practice at the home during our inspection and saw on many occasions that people were supported to answer the door to visitors. We observed a staff meeting being carried out on the second day of our inspection and saw two people were present. Agenda items were discussed which did not involve sharing information about people. Both people who had attended the meeting were given the opportunity to respond.

The service lead said they had an open door policy and were approachable to staff. Staff confirmed this and we observed that the office door was always open unless a private meeting was taking place. The service lead told us that upon their appointment into the role of service lead they had met with staff and identified staff morale was low due to staff working in isolation and not as a team. Following this meeting the service lead had supported staff to share responsibilities and attend training or a support session to learn how to complete their roles confidently. We saw a senior care worker was supported by the service lead to complete training bookings for staff using the computer database designed to hold information about staff's training. We heard the service lead speak to another member of staff about their new responsibilities and how they would be supported to achieve this.

Staff said management were very good and very supportive. One said, "Manager really good, I can approach them about anything and they would deal with it. I like working with them because they are really good to work with." Another said, "Manager great and their manager is great also." Staff confirmed they felt any feedback given to them from the service lead was constructive and motivating and they were clear on any actions they needed to take.

The service lead was supported by the provider's regional manager, who was not based at the home and there was an out of hours on call system run by the provider in place for both service lead and staff if they needed additional support.

Staff were supported to question practice and they demonstrated an understanding of what to do if they felt their concerns were not being listened to by management. One said, "If you have reported a problem, and it was not dealt with satisfactorily you can go to higher management or the Care Quality Commission (CQC)." Another member of staff pointed to a poster which displayed a help line number to support staff to whistle-blow. The service lead confirmed they would support and protect staff and people who raised concerns about other staff members.

The service lead had a good knowledge of people's needs and personalities and interacted well with them. They confirmed they had previously worked in the home as a support worker some time ago and knew the people well. They demonstrated a good understanding of their role and responsibilities and were proactive in identifying development needs of the service. For example, they had highlighted some achievements such as improving standards of support, staff using correct terminology, ensuring activities were more person centred, setting up the keyworker role and recruiting new staff. They had also highlighted some challenges they were facing at present such as dealing with staff performance and the need to update and review mental capacity assessments for each person.

There was a system in place to analyse, identify and learn from incidents, and safeguarding referrals. Members of staff told us they would report concerns to the service lead or out of hours regional managers and follow this up in writing. Incidents and safeguarding referrals had been

Good

Is the service well-led?

raised to the local authorities and CQC were notified of concerns. Management plans had been developed to help learn from incidents that had taken place and manage people's behaviour that may challenge others.

A number of audits had been completed to assess the quality of the home. Service Quality Assessment Tools (SQAT) had recently been completed by the service lead. This helped identify areas of improvement for the service and highlighted a need for mental capacity assessments to be updated for each person. Audits had been completed monthly for people's finances. The information was put into a planner which was completed using a computer database and any concerns were highlighted in red for the service lead to investigate. A financial audit had been completed in April 2015 showing no concerns. A service visit had been completed by the regional manager on 15 January 2015 which reviewed complaints, accidents and incidents, menus and food choices and other areas of health and safety including fire safety.

A business continuity plan was in place and had been updated and reviewed in December 2014. The business continuity plan would be used to provide guidance for staff on how to continue to deliver a service in the event of any emergency. For example, fire, extreme weather, utilities failure, chemical spill, transport collision or other local emergency that posed a risk to service users and staff in their home/work environment.