St. Cloud Care Limited

Stowford House Care Home

Inspection report

Faringdon Road
Shippon
Abingdon
Oxfordshire
OX13 6LN

Tel: 01235538623
Website: www.stcloudcare.co.uk

Date of inspection visit:
15 May 2018

Date of publication:
21 June 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 15 May 2018. At our last comprehensive inspection in January 2017 we gave the service an overall rating of 'Requires Improvement'. We made a recommendation about the management of some medicines. We also found that accident and incident recording needed to be improved. We needed to be sure that the service demonstrated consistent good practice in all aspects of the care over a longer period of time. At this inspection we found improvements had been made.

Stowford House a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation, nursing and personal care for up to 51 people. At the time of our inspection there were 37 people using the service. One of the units specialises in providing care to people living with dementia.

The service has 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 had a range of activities provided by the service to participate in. However, we heard from people and relatives that these could be improved. We have made a recommendation about improving activities.

People received their care and support safely. There were systems and processes in place to safeguard people from abuse and harm. People's risks were assessed and reduced by staff who understood how to protect people from improper treatment. People's medicines were stored securely and administered in line with the prescriber's instructions. Staff followed appropriate personal care and food safety practices to prevent infection.

People's needs were assessed and they receive the support they required to eat and drink. Staff were supported in their roles by the registered manager who delivered supervisions and appraisals and coordinated staff training. People had access to healthcare services whenever required. People were supported to have maximum choice and control of their lives and staff delivered care in line with the principles of the Mental Capacity Act 2005.

Caring staff maintained people's privacy and dignity. People were supported to maintain relationships with their relatives and friends. Visitors were made to feel welcome.

People had personalised care plans which detailed how they wanted staff to meet their individual needs. Information was available for people to access the provider's complaints procedure. The registered manager understood the provider's procedure for handling complaints and those that we saw were clearly documented. People received responsive and positive care at the end of their lives.

The registered manager had improved quality assurance processes since the last inspection which evidenced learning and sustainability. There was an open culture at the service and the views of people, relatives and staff were gathered. The service worked in partnership with other agencies to secure positive outcomes for people.

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 understood their responsibilities to identify and report concerns to protect people from harm and abuse.

Risks to people were assessed and plans were in place to guide staff on how to manage the risks.

There were sufficient staff to meet people's needs.

People received their medicines as prescribed.

People were protected from the risk of infection.

Incidents and safeguarding's were investigated by the service to ensure lessons were learnt and action taken where appropriate.

Is the service effective?

Good

The service was effective.

People's needs were assessed before moving to the home and reviewed on an ongoing basis.

Staff were supported and received training to ensure they had the skills and knowledge to meet people's needs

People received food and drink to meet their dietary needs.

People were supported to access healthcare services.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA) and their rights were protected. The registered manager took immediate action to ensure the Deprivation of Liberty Safeguards were all in place.

Is the service caring?

Good

The service was caring.

Staff showed kindness and compassion towards the people they supported and their families.

Staff knew people well and took time to build relationships with them.

People were treated with dignity and respect and their privacy protected.

Is the service responsive?

Good

The service was responsive.

People's care plans reflected their personal preferences and recognised them as unique individuals. Ongoing action was needed to ensure people's social needs were met.

Staff responded to people's changing needs in a timely and effective manner.

People had access to the complaints procedures.

People were supported with compassion at the end of their life.

Is the service well-led?

Good

The service was well-led.

The registered manager had made significant improvements in the service and there were systems in place to monitor and continue to improve the service.

People and staff were engaged so that their views were heard and acted upon.

The service worked well in partnership with other external agencies.

Stowford House Care Home

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 15 May 2018 and was unannounced. The inspection was carried out by two inspectors, one specialist nurse advisor in dementia and one 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. Their expertise was in care for older people and people living with dementia.

Before the inspection we reviewed information we held about the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send to us about significant events that take place within services. We asked for feedback from seven external health and social care staff and heard back from one.

We observed how staff interacted with people who used the service and monitored how staff supported people during the day by using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

During the inspection we spoke with 22 people, seven relatives, the registered manager, deputy manager and area manager. We also spoke with eight members of staff which included care assistants, nurses and the chef. We reviewed seven people's care records and four staff files. We also looked at documentation relating to the management and running of the service including policies, records of accidents and incidents.

Good

Is the service safe?

Our findings

At our last comprehensive inspection in April 2017 we gave the service a rating of 'Requires Improvement' in this key question. This was because not all medicine administration records (MAR) for topical creams or homely remedies had been completed or contained the relevant advice for administration. We made a recommendation that the provider sought appropriate advice to ensure current guidance was implemented in all areas of medicines.

We followed up this recommendation at this inspection and found the necessary improvements had been made. We reviewed seven medicines administration record [MAR] charts. These had been completed accurately with no gaps in recording. This showed people received their medicines as prescribed. Staff had guidance for the administration of people's 'when required' medicines. Medicines were stored securely and at the correct temperatures in line with manufacturer's guidance.

Staff administering medicines supported people to understand the importance of taking their medicines and stayed with people to ensure they had taken their medicines. We observed a nurse supporting a person to take their medicines. The nurse explained what the medicines were and asked how the person would like to take them. They ensured the person took their medicines at a pace that suited them offering encouragement and reassurance. Staff responsible for the administration of medicines had completed medicines training and had their competency assessed to ensure they had the skills and knowledge to administer medicines safely.

People were protected from the risk of neglect and improper treatment. One person commented, "I'm quite happy and safe here". A relative commented, "We needed a place of safety for [person]". Another relative said, "I've been impressed. It is a safe haven". Staff were trained to recognise and take actions if they suspected abuse and told us the actions they would take to keep people safe. These included reporting their concerns to the registered manager or the nurse in charge. Staff confirmed to us their understanding of whistleblowing and stated their preparedness to raise issues of people's safety with external agencies if the provider did not take action to keep people safe. Staff also stated their confidence in the registered manager and provider to take prompt action to protect people should a safeguarding concern arise.

Risks to people were detailed in care plans in areas such as eating and drinking, skin integrity, moving and transferring and falls. The risk assessments identified the level of risk and care plans included details of how risks would be managed. For example, one person had been assessed as at high risk of choking and therefore needed pureed meals. The person had lost weight when their care plan was reviewed and a management plan was put in place alongside food and fluid charts to monitor dietary intake. When the person was next reviewed their weight had increased. A relative commented, "I don't worry about her weight now that she is here". Premises and equipment were maintained to ensure they were safe for people to use. For example, there were effective systems in place to monitor and maintain fire systems.

People told us their needs were met in a timely manner. One person told us, "I use the buzzer/alarm and someone always comes". Another person said, "If the buzzer goes the response is good". Relative's

comments included, "Downstairs the number of staff has improved and if [person] needs some care she gets it"; "I have no problem with staff numbers, even at weekends"; "Yes, I always see several staff, probably enough, Fridays and Saturdays usually look fine on numbers too" and "There always seems to be enough carers around".

Staff we spoke with felt that staffing levels were sufficient to meet people's needs. One member of staff told us, "Staffing levels are fine. We do have time to sit with people and chat". Another member of staff said, "We have enough staff; sometimes it's short if someone is sick but they always call for agency". Throughout the inspection people's requests for support were responded to in a timely manner and call bells were answered promptly. People who chose to remain in their rooms were visited regularly by staff and staff took time to check on people as they passed their rooms. We looked at staff rotas for four weeks and saw that assessed staffing levels were consistently met.

There were effective recruitment processes in place that ensured checks were carried out prior to staff starting work at the service. This enabled the provider to make safe recruitment choices.

The home environment and staff practices minimised people's risk of infection. Staff received training in infection prevention and control and we saw that hand sanitising gel pumps were available throughout the service including bathrooms, the reception area and along corridors. Staff wore personal protective equipment (PPE) when delivering personal care to people. Kitchen staff wore additional PPE including aprons and hairnets. The service had a policy which prevented kitchen and laundry staff from entering each other's areas of work. This practice was in place to prevent staff from inadvertently spreading potentially harmful bacteria.

The provider had systems in place to investigate and review safety and safeguarding incidents when things went wrong. These were overseen by a strong governance procedure ensure trends and patterns were identified. These were shared with staff to improve safety across the service.

Good

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home was mostly meeting the requirements of DoLS and applications for a Deprivation of Liberty Safeguard (DoLS) had been submitted to the supervisory body.

However, we noted there was some restrictive practice in place involving the use of stair gates. These were been used to protect people from disturbance in their rooms by residents with dementia care needs. Where these are considered necessary, this should be used as a last resort and any decisions made must be well and appropriately recorded within the care plan and continue to be reviewed. We saw no documented evidence of the decision making processes. A risk assessment had not been completed for hazards associated with an individual trying to climb over the stair gate. We raised this issue with the registered and deputy manager on the day of the inspection. Risk assessments were completed immediately. Following the inspection we received confirmation that records now reflected that the stair gates in use are the least restrictive option. These decisions had involved the person where they had capacity and a best interest decision involved the relatives where appropriate. The DoLs team had been updated to consider the restriction when they assess the DoLs application. Until this time, the restrictions will be reviewed monthly.

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 had received training on the principles of the MCA but their understanding was variable on the day of the inspection. However, we saw that in practice staff worked to the principles of the MCA. For example, staff took time to explain choices to people and supported them to make informed decisions about their care. Staff ensured they gained consent from people before supporting them to meet their needs.

People's needs were assessed and care plans reflected those needs and how they would be met. Care plans ensured that effective outcomes were identified and were in line with current legislation and guidance. For example, people's communication needs were identified and recorded in line with Accessible Information Standards. (AIS) framework. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

Care plans reflected people as unique individuals and took account of any protected characteristics in line with the Equality Act 2010. For example, one person was identified as having difficulty communicating which was associated to their disability. The person's care plan guided staff to listen carefully to the person when they spoke and ask them to repeat what they said to ensure understanding. The care plan also stated, 'May

feel patronised if you pretend to understand her when you don't'. This ensured the person's rights were protected by ensuring they were listened to.

People were supported by staff that had the skills and knowledge to deliver effective support. One external professional commented, "[Deputy manager] in particular is passionate about high standards of care and this is clear from the discussions I have had with her". The registered manager had an appraisal, supervision and training plan that identified when supervisions were due to be completed and any training that was due to be updated. Staff told us they were well supported. A member of staff said, "[Registered manager] is really supportive. We can go to her and she'll sort things". Staff were positive about the training they received. One member of staff said, "[Registered manager] has encouraged me to find courses I want to do". Staff were supported to identify development opportunities and the registered manager was extremely supportive of people's achievements. For example, encouraging and developing champion roles in areas such as continence and tissue viability. Champions were also in place for infection control, dementia, safeguarding and dignity and respect. Their roles were focus on these areas of the service to assess whether any changes or improvements may be needed.

Care plans contained nutritional assessments and people's weight was recorded monthly. The food served on the day of the inspection was nicely presented and looked appetising on the plate, including pureed food. People's comments included, "The chef is good; he was deputy and has bloomed since his promotion" and "The food is excellent, really excellent". Where people had been assessed as being at risk of malnutrition or dehydration, care plans provided clear guidance for staff. We observed staff encouraging people to drink throughout the day, including those that chose to stay in their rooms. This showed that staff were assisting and encouraging people to take fluids to prevent dehydration and urine infections.

During lunch in one of the dining rooms, people were eating at shared tables as well as individual tables and members of staff served pre drinks before lunch. The meal experience appeared social as some people were chatting to each other and staff. In one of the rooms four people were being assisted with eating. One person on a safe swallowing plan was being supported correctly and was sitting upright. Staff assisting him knew the consistency of his drinks as recommended by the Speech and Language Therapy (SALT) team and also said the person liked his TV on when having lunch. This showed staff were aware of people's needs and how to meet them.

People had access to a range of health professionals to support their on-going health needs. Records showed that people had been visited by GP's, SALT, Tissue Viability Service, and people supported to attend hospital appointments. Where recommendations had been made, these had been incorporated into people's care plans to ensure those recommendations were followed. For example, a person was seen by the SALT team in May 2017 and safe swallowing plans were recommended. The person's family had been consulted and involved in care plan reviews. A relative commented, "[Person] had throat and chest infections. They were on them very quickly". Another relative said, "[Health professional) came in to do an assessment with the home's nurse around monitoring fluids. It was successful and all is going very well now". The Care Home Support Service (CHSS) also visited regularly to support the service. We were told, "The care home refers to me and acts on the advice. I discuss the care of the residents and often this just helps facilitate an action plan. The care home are able to come up with plans themselves. They are skilful and considered in their approach to care and highly experienced too".

The environment was clean and odour free. There was access to the garden and we saw people enjoying sitting out. The registered manager had reported in their provider information return that they planned to improve the environment within the dementia unit to ensure it met people's needs.

Good

Is the service caring?

Our findings

People continued to receive care and support from staff that were caring. Comments from people in the service included, "I can laugh and joke with all of them"; "The main carers are lovely; they come up and hug me sometimes"; "They are wonderfully natural, kind and do whatever people need; they don't need to be asked" and "The carers always get to my level and kneel to the floor". Relatives comments included, "I cannot speak highly enough of the carers and staff, they're always smiling and even on the odd occasions when they're understaffed they always do their best and cope"; "[Name of care staff] gave [person] a lot of extra care and that was a lifeline for her" and "All the carers are lovely, I see a constant although at weekends some are different". An external professional commented, "In terms of attitude and conduct I have only seen positive. For example, willingness of care staff to provide assistance. There is always a positive and willing attitude there".

We observed some positive caring interactions between staff and people using the service. We observed staff reassuring people when anxious, using gentle touch and making eye contact and listening to concerns. People appeared to be enjoying themselves and some people sat in the garden and they appeared comfortable and content. We observed staff chatting to people and these interactions appeared natural. For example, the chef was chatting to people in the garden and said he liked to engage with people during this time when it was quieter in the kitchen. One person told us, "The staff are kind and I get the care I need." Another person said, "Staff are kind to me."

Staff had received equality and diversity training to ensure people were treated with dignity and respect and to ensure people and staff's human rights were respected. Care plans were person centred ensuring people's individual needs, choices and preferences were met. The service had sought accessible ways to ensure people with protected characteristics under the Equality Act received communication in a way that met their needs. For example, information was printed in easy read format, large print text and in pictures. There were large print books available for those with visual impairments and talking books and papers could be obtained. The service also used, picture boards, pen and paper and visual aids for people with loss of hearing.

Staff respected people's privacy and dignity. Staff knocked on people's bedroom doors and waited to be invited in before entering. When in the room, they spoke to people in a friendly and respectful manner. Personal care was delivered with bathroom and bedroom doors shut and towels were used to ensure people did not feel exposed. We heard of one person had stated when bathing they wanted to wear their underwear to protect their dignity. This was respected. Staff understood the importance of ensuring privacy and dignity and one commented, "Make sure we keep people covered; stand outside if someone is using the toilet and always knock on doors before going in".

People's independence was respected. One person enjoyed propelling themselves around the home in their wheelchair. When they were not able to do this, they became miserable and bored. Therefore, the footplates had been removed and the person chose to not wear footwear. This preference had been carefully risk assessed and incorporated into their care plan. On the day of the inspection we saw the person enjoying

moving around independently.

Staff understood the importance of ensuring people were supported to maintain relationships with those who mattered most to them. People's relatives and friends were made to feel welcome when they visited the service. Staff offered visitors refreshments as well as privacy if they chose. A couple had initially been admitted into separate rooms. They were not happy and therefore one room was converted into a bedroom and the other to a private sitting room where they could spend time alone together.

People's confidential private information was protected in line with legislation. People's care records were computerised and protected by passwords in a locked room and could not be viewed by visitors. This meant people's personal information remained confidential. The registered manager was aware of the implementation of the General Data Protection Regulation (GDPR). From May 2018, GDPR is the primary law regulating how companies protect information.

Good

Is the service responsive?

Our findings

At the last inspection, people's comments about the activities offered were positive. At this inspection we found that people's views were more variable and some people told us there were not enough activities to keep them occupied. There were two activity co-ordinators in post and one vacancy. Comments included, "Nothing so much to do now that [staff name] has left"; "I'm fed up really; I haven't been taken out for some time", "I would like to play chess, I have a board but no one to play with"; "[Staff name] has left. [Staff name] is hands on and changed and improved things but we were promised a third person but it has never materialized", "We need more music"' "We need more things to do" and "I get bored and fed up sometimes". Therefore, we were not sure activities were reflective of people's interests.

We also heard the home had a mini bus but due to the activity staff not being able to drive meant it had not been used in recent months. A relative said, "They haven't been out for months. [Person] used to love going out, just simple things like going to [supermarket] to buy a couple of things". Another relative said, "You would think that they would prioritize getting someone to drive the van and they keep telling us that they will advertise the job". Another relative had a PSV licence and had volunteered to drive the van but said their offer had not been taken up. We informed the registered manager of these comments. They said that there were meetings held and activities were discussed at these. However, they would continue to engage with people and their relatives in response to these comments to improve this area of the service.

We recommend the provider looks at good practice guidance in relation to activities for people living in care homes and continues to engage people to ensure activities reflect people's individual interests.

On the day of the inspection we saw people engaged in some activities. For example, a seated exercise programme. Other people were sat in the garden and they appeared comfortable and content. The registered manager said an activities schedule is given to people, their families and displayed throughout the home. Oomph training has been undertaken by the activity team to enable exercise to be included in the programme. We saw the activity programme was reviewed and discussed at meetings with people. We heard that the home celebrated certain events such as the Queen's birthday, royal weddings and the national care home day. Two local schools were regular visitors to the home to join in activities with people. Work experience was available for students undertaking health and social care education at the local college. People were supported to vote either in person or by post. We had comments from people such as, "I like the activities that involve animals". Another person said a volunteer from the local library visits once a fortnight, "Bringing in six books each time". We also saw that some people had computers of their own.

People's assessed needs had been integrated into care plans which guided staff how to meet those needs. People's preferences had been documented and when we case tracked people we saw that these preferences had been followed. For example, in one plan it was documented that the person liked to go bed and get up at certain times. It also noted that the person liked to visit and have lunch with their [relative]. During the latest review an action plan had been set to implement this and we saw this was happening.

The service was responsive to people's changing needs. Care plans were reviewed monthly, or whenever

there was a change in people's needs to ensure they were up to date. Relatives were invited to be involved in reviews. A relative told us how a person had progressed since moving into the home. They said, "[Person] has really improved; two or three months ago he relied totally on being hoisted but now can stand up by himself and wait to be lifted. An amazing improvement".

Staff we spoke with knew people well and had a person-centred approach to supporting people. A person said, "They all know me, they all know my name". We observed a person who needed a high level of support. This person was mostly receiving one to one support. Care staff demonstrated good knowledge of how to respond to the person, particularly when they were distressed.

The registered manager and staff understood the importance of supporting people to have good end of life care. We saw emails and cards of thanks from relatives regarding the high quality care people had received. Health professionals were involved in determining people's needs at this time. The local hospice referred people to the service and supported the staff team with the delivery of end of life care. One person had been prescribed medicines to ease symptoms so they were in place in case their condition worsened and pain increased. People's preferences about their end of life had been recorded, stating whether they wished to remain at the home when the time came rather than go into hospital.

The service had a complaints procedure which people and relatives understood. People and relatives knew how to make a complaint and were confident issues would be addressed. A relative said, "I'd go to whoever was in charge, I can't do anything else". Records of all historic complaints, investigations and findings were kept by the registered manager. These were periodically reviewed by the registered manager for patterns and trends to prevent any causes of dissatisfaction recurring.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection in April 2017 we gave the service a rating of 'Requires Improvement' in this key question. This was because the inspection took place six months after the service had been placed into special measures. Therefore, we needed to be certain that the improvements we found were embedded into the service and that they were sustainable. At this inspection we found that changes had been sustained and improvements continued.

In the past year, the organisation had been restructured to include a strengthened compliance team. The regional manager visited monthly and provided a regional managers report, covering, care planning, observations of care, checks of record keeping and environmental checks. A new registered manager was in post since the last inspection and was committed to ensuring the culture of the service and staff attitudes, values and behaviour were maintained. The registered manager said, "I feel it is important to be visible as a manager. I try to support the team and hope to have broken down the culture of blame and bullying".

People and relatives were positive about the management of the service. A person commented, "There is no doubt that staff are better and happier than before". Relative's comments included, "The registered manager has been able to bring things together and is getting the best out of the team"; "Now there is far more openness" and "The registered and deputy managers are an entirely different kettle of fish. It is nicely managed and trained up". We heard that communication had improved. One person said, "Now when I come in I never have to ask how she has been. The first person tells me her state, the situation, when she's eaten, often there is someone sitting with her and often touching; she clearly benefits".

All staff interviewed spoke highly of the new management saying, there was a lot of positive energy in the team because they felt supported and valued. A member of staff said, "Everyone seems more uplifted and morale is much better. Definitely a better team spirit". A member of agency staff said they had recently returned to work at the service on a regular basis. They commented that, "Staff morale had improved following the change in management". This meant they felt able to return to work in the service as working relationships were now more positive.

The registered manager carried out daily 'walk around' in order to identify any areas of improvement and also held daily meetings with heads of department to identify and address issues. Each morning the head of departments held a short meeting to ensure they were aware of any issues that may needed attention or knowledge.

There were effective systems in place to monitor and improve the service. Audits were completed by the registered manager and deputy managers, nursing staff, care staff and the compliance team to ensure a wide perspective on the quality of the service. These audits covered areas such as health and safety, accidents and incidents, care plans, food, infection control, staff records and staff training. External audits, such as pharmacy, were also undertaken.

The registered manager coordinated regular team meetings and records showed that these were used to

discuss changes in people's care and support needs, operational practice and other important information. Staff told us they felt comfortable sharing their views during team meetings. A member of staff said, "We have monthly team meetings. It's better now as [registered manager] asks us for agenda items so she knows if we've got any issues".

People and their relatives were invited to develop the service being delivered. Regular meetings for relatives were held where people could share their views on issues such as food, activities or any other views they wanted to discuss. A relative told us, "The first one was crammed and held upstairs. A lot of people were stressed by what was going on, but now only 6 or 7 people come". They felt this indicated that relatives were less concerned now.

There were systems in place for the provider to gather the views of people, relatives and staff about the quality of the service such as quality assurance surveys. The registered manager told us the responses would be analysed by the provider and an action plan developed as a result.

The service worked in a collaborative way with other agencies. In particular the service liaised with the local authority and healthcare professionals. The registered manager was also building links with the local community such as schools and colleges. The provider was also working with Impact Futures to offer apprenticeships in the service.

Technology was being considered. For example, the provider was trialling some new technology that captured data when placed under people's mattresses. This included heart and respiratory rate, and movements which was then sent to a computer to provide information to monitor and analyse. This meant ways to more effectively monitor and improve the quality of care were being considered.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. We saw the registered manager understood and met the legal requirements, including informing CQC of reportable events.