Education and Services for People with Autism Limited

Cedars Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 December 2017 and was announced. This meant we gave the provider 24 hours notice to ensure there would be someone at the service when we visited. We did this because it is a small service where people are often out during the day.

We previously inspected Cedars Lodge in October 2015, at which time the service was meeting all regulatory standards. At the inspection of October 2015 we rated the service as good. At this inspection we rated the service as requires improvement.

Cedars Lodge is 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.

Cedars Lodge is a small dormer bungalow near Sunderland City Centre in its own grounds. The service provides care and support for four adults who have learning disabilities.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They had taken over the management of the service three weeks prior to the inspection, following the resignation of the long-term registered manager.

Medicines had not been effectively audited and we found instances of poor practice in relation to topical medicines, medicines administration records and homely remedies.

We found areas of good practice with regard to medicines prescribed to be taken 'when required'. De-escalation strategies were used well to ensure staff did not overly rely on medication to help reduce people's anxieties.

People who used the service felt safe and behaved in a manner that demonstrated they were comfortable with and trusting of staff. Relatives and external professionals raised no concerns about people's safety.

There were sufficient staff to meet people's needs safely and staff had received training in safeguarding.

All areas of the building were clean and well maintained by the provider.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service checks, references and identity checks.

Risk assessments were detailed, person-centred, involved people in their planning and practice and gave staff clear guidance about how to help keep people safe.

People had access to a range of primary and secondary healthcare, such as GPs, nurses and psychiatry.

Staff were trained in a range of core areas such as health and safety, medicines administration, infection control, first aid and fire safety. Staff had also received training to equip them to better meet the needs of people who used the service, such as autism awareness, epilepsy awareness and how to identify and de-escalate challenging behaviours.

Staff had not always received regular supervisions or regular team meetings. Staff told us they were well supported otherwise and that they could raise any concerns they had on an ad hoc basis. The new registered manager had planned supervision sessions and team meetings.

People were involved in shopping and preparing meals and helped themselves to drinks and snacks during our inspection.

The premises were well suited to people's needs, with en suite facilities and ample dining and lounge space.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People who used the service received a good continuity of care from a stable team of staff who knew them well and there was an effective keyworker system in place, with information handed over at each shift.

The atmosphere at the home was welcoming, relaxed and inclusive, with people encouraged to exercise choice in day-to-day decisions and longer-term choices, such as their education and employment. People who used the service had achieved a range of positive outcomes with regard to developing their independence.

Person-centred care plans were in place and contained good levels of detailed, although this was not always easy to cross-reference as it was held across a number of files. Regular reviews of care plans took place with people and their relatives involved.

Staff were extremely positive about the new registered manager's impact, confirming they felt supported and more empowered than previously. We observed people interacting comfortably with the registered manager and deputy manager, and there was no evidence of the recent change of leadership having a detrimental impact on people.

The culture at the service was open and inclusive, with staff encouraged to contribute ideas and a registered manager who was receptive to feedback.

Improvements in terms of quality assurance and scrutiny were required, particularly with regard to medicines and care files. The registered manager acknowledged this and had an action plan in place detailing who was responsible for these actions and when they would be completed by.

We found the provider to be in breach of the regulations in relation to the safe administration of medicines. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines administration practices were not always safe, particularly homely remedies and topical medicines. Auditing was not thorough and had not identified these areas of poor practice.

People who used the service felt safe and appropriate safeguarding training and policies were in place.

The premises were clean and well maintained.

Is the service effective?

Good

The service was effective.

Staff had received a range of core training and additional training specific to the needs of people who used the service, for example epilepsy awareness and autism awareness training.

People experienced good health outcomes through regular access to primary healthcare professionals.

People were encouraged to eat healthily and to take part in the planning and preparation of their meals.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives provided positive feedback about the patience and caring attitudes of staff.

People who used the service had built a good rapport with staff members and their peers, and felt at home.

Staff demonstrated an excellent knowledge of people's needs, preferences, life histories and relationships.

Is the service responsive?

Good

The service was responsive.

People were supported and encouraged to access a range of individual and group activities and pursuits meaningful to them.

People were supported to maintain and develop their independence skills and took part in the wider community.

Complaints processes were readily accessible and people's suggestions and concerns were listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits had yet to be improved since the arrival of the new registered manager. They had developed an action plan, which set out who would be responsible for ensuring improvements happened.

Team meetings and staff supervisions had not happened as often as they should have in the previous year.

Staff confirmed the new registered manager was open to ideas and suggestions and had been supportive since taking over.

Cedars Lodge

Detailed findings

Background to this inspection

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

We visited the service on 5 December 2017 and the inspection was announced. We do this to ensure that someone would be at the service on our arrival. The inspection team consisted of one Adult Social Care Inspector 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 service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. We spoke with one external social care professional.

We spent time speaking with three people who used the service and observing interactions between staff and people who used the service. We spoke with four members of staff: the registered manager, the assistant manager and two care staff. We also spoke with relatives of the four people who used the service. During the inspection visit we looked at two people's care plans, risk assessments, staff training and recruitment files, medicines records, quality assurance documents and systems, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Requires Improvement

Is the service safe?

Our findings

We found there was currently insufficient oversight of medicines administration procedures, meaning a range of areas of poor practice had yet to be identified or improved. For example, one person had indigestion tablets in the medicines cupboard but the service had yet to establish with the General Practitioner (GP) whether these could be used safely alongside the person's prescribed medicines. The registered manager agreed they needed to seek advice from the GP in relation to 'homely remedies'. These are non-prescription medicines. The registered manager sought advice from the GP the day after the inspection.

Medicines Administration Records (MARs) we viewed contained no errors in terms of when medicines had been administered and recorded, but not all people's records had a photograph of them on the MAR. The registered manager agreed to rectify this as a priority. We saw that people who used the service were supported by staff who had known them for a period of time and that the service did not use agency staff. The risk therefore of the absence of photographs leading to a medicines error was low.

We saw one instance where a person's prescription of a topical medicine (a cream) was not supported by adequate guidance for staff. The administration instructions did not include directions regarding whereabouts on the person's body to apply to the cream, nor was there a body map to identify this. The registered manager agreed, "There should be body maps in place." Again, whilst we identified poor practice, the risk of a medicines error was low as all staff we spoke with demonstrated a good knowledge of the person's medicinal needs. There was however the risk of maladministration should a new member of staff need to refer to such documentation.

We found the auditing of medicines to be insufficient. The auditing of medicines completed by the outgoing registered manager consisted of regular stock checks but did not demonstrate an analysis of how medicines were administered or staff practice.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there had been a recent external audit conducted by the provider's health and safety team. This had identified that staff competence regarding the administration of medicines had not been documented recently. We saw as a result staff competencies had all been completed in the same month in response. When we spoke with staff, they demonstrated a good knowledge of people's medicinal needs.

We found some aspects of good practice, for example protocols to help staff in their administration of 'when required' medicines. There was detailed guidance in place with clear direction towards de-escalation strategies rather than a dependence on medicines. This was reflected in the provider's policy. We found no evidence of an over-reliance on sedative medicines and a range of skilled de-escalation techniques employed by staff. A sample of controlled drugs demonstrated stock levels were correct. Controlled drugs are medicines that are liable to misuse. Medicines were kept in a locked cupboard in the registered

manager's office, with daily temperature checks in place.

People who used the service and their relatives confirmed they felt safe at Cedars Lodge and no concerns were raised by external professionals. One person told us, "I love it and I'm absolutely fine – the staff are great." Relatives told us, for example, "Without a doubt the service is safe – he is totally happy and his needs are met," and, "They keep an eye on people and the building is secure – no problems on that front." We observed people interacting with all staff in ways that demonstrated they felt secure and comfortable.

All staff had received safeguarding and whistleblowing training and those we spoke with were aware of their responsibilities and able to clearly articulate what they would do if they had concerns. We saw there had been one incident earlier in the year whereby staff had not adhered to a policy regarding how to cope with behaviours that could challenge. External agencies were notified, an investigation took place and appropriate action was taken regarding individual staff and awareness of the policy moving forward. The then registered manager also shared the lessons learned from the incident with the provider's other registered managers. This demonstrated that the provider was able to reflect on individual incidents to ensure it learned from when mistakes had been made.

We reviewed staff rotas and found there were sufficient staff on duty to keep people safe and meet their needs, during the day and night. There were on-call arrangements in place which were clearly accessible in office, meaning staff always had access to support from senior staff if needed.

Risk assessments were detailed and individualised to people's needs and preferences, helping staff to understand how best to help people avoid the risks they faced. This was done in manner that did not restrict people's freedoms. For example, one person wanted to visit various people using public transport but there was a level of risk in terms of their potential vulnerability in the community. Staff had practised the routes with the person until they were comfortable doing it on their own, and clear controls were agreed, such as the person charging their phone before departing and agreeing the duration of the visit in advance. A relative confirmed, "They came with him at first and I met them at the other end, but he's been doing it independently for a few months now." This meant risks were well managed but had regard to people's rights and preferences.

Pre-employment checks, including identity checks, references and enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. This meant the service had a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

The premises were clean throughout and in a good state of repair. One relative confirmed, "It's always clean and tidy." Staff were responsible for the cleanliness of the service and had received infection control and food hygiene training. We saw there was ample personal protective equipment available. This meant people were protected against the risk of acquired infections.

Regular checks, by staff and by external contractors, were in place to ensure the premises were appropriately equipped in the event of an emergency. For example, emergency lighting, fire extinguishers, detectors and doors, whilst fire drills happened regularly. Periodical electrical inspections and servicing of gas boilers had been regularly completed. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

Accidents and incidents were consistently recorded and had been shared with the provider's area

management so that they could analyse whether there were any developing trends across multiple sites.

One person who used the service had a personalised emergency evacuation plan (PEEPs) in place, which detailed their mobility and communicative needs. Other people who used the service did not have a PEEP in place and did not require additional support to evacuate the premises. The registered manager agreed to include this information in the emergency grab bag, so that members of the emergency services had clear information about all people who used the service should they need to in the event of an emergency.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they felt staff were well skilled and appropriately trained to meet their needs. For example, one person told us, "They are spot on," whilst relatives said, "They all have specialist training and make sure he has dentists, doctors, hairdressers, everything," and, "They know what they are doing. He is making tiny steps and progressing not regressing."

Staff received a good range of training as part of the induction and on an ongoing basis. The provider's training manager provided registered manager's with a calendar of training required for the year. Staff had been trained in core areas such as safeguarding, first aid, infection control, food hygiene, fire safety, mental capacity awareness and equality and diversity. Staff also received training specific to the needs of people who used the service prior to delivering care, for example autism awareness, epilepsy awareness and 'Studio 3'. This is a three-day course to give staff the skills required to identify and respond appropriately to behaviours that may challenge. This was delivered by a British Institute of Learning Disabilities (BILD) accredited trainer.

Induction materials demonstrated a comprehensive overview of the service's policies, procedures and mission statement, and staff we spoke with confirmed they had been well supported when joining the service.

We saw people who used the service received a range of good healthcare outcomes thanks to well planned support by staff and regular access to primary healthcare professionals. People's needs had been assessed prior to using the service and regularly reviewed since. One relative told us, "They put out the care plan well in advance for comments." One external healthcare professional told us, "Their understanding of autism is very good."

Dentist, chiropody and opticians appointments were well planned in each person's health file, which contained their health action plan. A health action plan is designed to enable people with learning disabilities to be involved in their care planning and to ensure relevant health information is accessible in one place. Where people required more specialised support, for example from the Speech and Language Therapy Team and psychiatry professionals, this information was incorporated. Where people had specific needs there were specific plans, for example an epilepsy management protocol. This outlined a person's history, triggers, indicators and actions for staff.

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

People can only be deprived of their liberty to receive care and treatment when this 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 saw appropriate documentation had been submitted to the local authority regarding the DoLS.

We checked whether the service was working within the principles of the MCA. We found the registered manager and staff we spoke with to have a good understanding of capacity, for example that it should be presumed and, where people did not have capacity, this should be considered for specific decisions. Where a person did not have capacity to make decisions we saw people's relatives and those who knew their needs best were involved in decision-making. Where people had capacity to consent we saw they had done so in care planning documentation.

The premises were well suited to the needs of people who used the service and were in keeping with 'Registering the Right Support', a Care Quality Commission guidance document on residential services supporting people with autism and/or a learning disability. The service was small, homely, and had ample communal spaces were people felt comfortable relaxing. Relatives told us, for example, "The kitchen is very good and the house fits his needs."

Staff told us they were well supported but acknowledged they had not received formal supervision meetings, "As often as they would like," under the previous registered manager's leadership. One staff member stated these meetings had, "Tailed off". Supervision is a formal meeting between an employee and a line manager to discuss their workloads, and training needs or areas they need to improve. The registered manager was aware of the recent lack of formal supervision meetings and we saw they had planned this work as part of the action plan they had drawn up since taking over the role.

People who used the service prepared their own meals for the most part and were supported by staff to make their own shopping and cooking choices. Where people were at risk of putting on excessive weight their weight was monitored. Healthy eating plans were also in place to encourage people to choose healthier alternatives, although staff respected their wishes to choose less healthy options. Relatives told us, "They are proactive and help him do his shopping so it's him doing it rather than them leading," and, "His diet is expanding and he has fruit every day – they encourage him to go into the kitchen and cook."

There were two dining tables, each with enough room for people who used the service to enjoy meals together or have snacks on their own. We observed people making their own drinks and snacks throughout the inspection.

Good

Is the service caring?

Our findings

People who used the service and their relatives gave us consistently strong feedback about the attitudes of staff and how they cared for people. One person who used the service told us, "[Staff member] is excellent and really helpful," and another said, "Brilliant." Relatives praised the patience and calmness of staff, saying, "I can't fault the staff," and, "The staff are most kind and welcoming and they let him get on with what he wants to do."

We observed staff and people who used the service interacting in a relaxed manner, clearly at ease with each other. The caring relationships between care staff and people who used the service had been built over a period of time and, due to low staff turnover and a keyworker system, there was a good level of continuity of care. This meant people who used the service, who could be particularly susceptible to anxieties regarding change, were assured that they received support from the same members of care staff wherever possible.

People told us they felt at home and were relaxed in the environment, making drinks and snacks when they felt like it and chatting to the registered manager and assistant manager in their office, the door of which was kept open. One relative told us, "Staff are so respectful. Over the years, if there have been any issues, they have updated us. They are really patient."

An external professional told us, "Of the places he has been, this is by far the best and most welcoming." We found people answered the doorbell when it rang in a pleasant, friendly manner, and relished treating the service as their home.

People treated the service as a home and we saw there were numerous photos on the wall of people taking part in activities, along with a poem written by a person who previously lived at the home. People were consulted and involved in the decoration of their rooms, which we saw were personalised to their tastes.

People had made friendships with others who used the service and we observed some examples of a clear rapport between people. We observed people joking with each other about going to a party, and talking about the latest developments in a soap opera they both followed.

People were treated in a respectful and dignified manner and staff were sensitive to people's varying levels of independence, ensuring they were supported with tasks but without taking over from people. People's wishes were respected, for example regarding the balance of how much help they felt they needed with regard to personal care.

People were treated as autonomous members of society and their wishes were respected and supported where possible. People were enabled to maintain relationships important to them, for instance with family members or external friendship groups. We found these relationships meant people had a wider range of opportunities to engage with the wider community and develop their independence. Staff helped for instance by keeping a list of each person's relatives' birthdays so they could be reminded about sending a

card.

Advocacy services were available and, where one person had an advocate, we saw they were routinely involved in the person's care reviews. Staff sought their opinions to ensure the person who used the service had their best interests represented and respected.

In terms of other ways of routinely encouraging people to be involved in planning their care, we found house meetings had declined recently. This was another area where the registered manager and assistant manager planned to make improvements and reintroduce these meetings. We did find however, on speaking with all people who used the service, that they felt involved in planning their care and were always consulted. Relatives and an external professional we spoke with also confirmed this to be the case.

Good

Is the service responsive?

Our findings

People who used the service were supported to pursue a range of activities meaningful to them by staff who understood their like and dislikes. There were a range of in-house activities available for people, such as board games, computer games and film evenings and people told us they enjoyed taking part in these. There were also a range of external activities that people attended, sometimes with the support of staff and sometimes on their own. There was a good balance of opportunities for individual and group activities, such as going to see the switching on of the Sunderland Christmas lights.

People told us they were supported to follow their interests and gave us examples of what they had chosen to do this week, for example going to a disco, going to the shops, visiting family members and friends, playing computer games.

People were supported to pursue areas of interest as independently as possible, including access to education and work. For instance, one person had recently enrolled to complete a diploma in entrepreneurship, along with a food preparation course. We saw one person had a regular role volunteering at a local hospital and had made peer and friendship links through this role. People were planning their futures with the help of staff support regarding practicalities, for instance, help with claiming relevant benefits. One relative told us how supportive staff had been in this respect, helping one person to understand the benefits process and ensuring they contributed as much as they were able to completing the paperwork. One person had recently moved out of the service into an independent supported living environment and we spoke with another person who was planning this with the help of staff.

Relatives confirmed, "He goes off to Newcastle regularly with a mate, he likes to do things for himself and the staff help with that," and, "It's person-centred - they take notice of what's important to people and focus on it."

The registered manager showed us the Spectrum Star tool, which they planned to implement. The star helps staff and people who use services map their progress in a range of areas to help plan towards specific goals. Whilst this tool had yet to be implemented, we found evidence that people who used the service were supported to attain a range of individualised goals with the help of staff.

We found care plans contained comprehensive levels of information regarding people's backgrounds, interests and preferences. Whilst this information was spread through a number of care files and was not always easy to access instantly, it was thorough and up to date in its content and staff demonstrated a sound knowledge of the contents. Care planning was person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. The registered manager showed us how they planned to streamline some of this information so it was easier for people who used the service, staff and external professionals to access. Staff told us they felt the new documentation would be a significant improvement.

Care files we reviewed contained hospital passports. A hospital passport details people's communicative,

medical and mobility requirements should they need to go into hospital. This meant information relevant to people's needs could easily be shared with other healthcare professionals if needed.

When we spoke with staff they knew about people's individual needs and preferences, for instance one person's fascination with wildlife and how they helped them explore and access local facilities such as aquariums.

Staff understood people's communicative abilities well, particularly where one person required more tailored approaches to communication. For instance, where one person was prone to repeating phrases they heard (echolalia), there was clear guidance in place for how staff should respond in order to ensure they knew the person had understood what they had asked and could be involved in the conversation. All staff we spoke with were aware of people's communicative needs and were able to meaningfully engage with people.

With regard to complaints, we saw people who used the service were encouraged to raise any problems or concerns they had through individual discussions with staff or through the reviews of their care plans. There was a formal complaints policy and procedure in place. We saw the service had received no formal complaints but people who used the service had raised concerns about interactions with other people using the service (for example excessive noise). Where these concerns were raised we saw they had been looked into and an outcome documented. People told us of staff, "They are canny at listening," and confirmed they were supported to raise any issues they had. An external professional agreed: "If he ever has an issue they listen to him and try and resolve it with him."

Whilst no one who used the service needed end of life care at the time of our inspection, the registered manager showed us how they planned to ensure staff were trained in this area and that people who used the service had a better opportunity to talk about, for example, advance care planning. Advance care planning is a means of using personal values and preferences to plan future care. This is to help ensure care is consistent with people's values, goals and preferences should they suffer serious and chronic illness.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post for less than a month at the time of the inspection. They had extensive experience of caring for people with learning disabilities and were also the registered manager of one of the provider's other locations nearby. At the time of the inspection they were reviewing all aspects of the service to ensure the new assistant manager (who would in time be responsible for the day-to-day running of the service) was supported to gain a full understanding of the service. We found the registered manager and assistant manager worked well as a team and had clear plans in place regarding how to make improvements to the service and to ensure these were sustained.

Improvements were required with regard to the ongoing auditing of processes within the service. Auditing of medicines was not fit for purpose and there was no independent auditing of people's care records by the previous registered manager. Changes regarding people's individual needs had been identified and made during care reviews but this was not the same as the registered manager having oversight of a systematic auditing of service provision that could have picked up on improvements to be made or common errors. The only auditing of this kind that had taken place was the external assessment by the provider's health and safety and quality assurance colleagues.

The registered manager acknowledged that they had not had the handover they would have liked and that they were still finding areas where changes were required. They shared the action plan they had developed to date, which identified the areas for improvement and dates by which these improvements would be made. The registered manager and assistant manager had therefore analysed a range of areas that had not been adequately audited in the past year. This meant, whilst the service had not benefitted from appropriate auditing and manager-level engagement prior to the current registered manager taking over, this was now planned. The registered manager was responsive to feedback during the inspection and corrected any minor issues identified immediately.

Staff told us they had not previously been empowered to take on extra work but that, since the arrival of the new registered manager, they had received additional delegated duties, which they welcomed. Staff said, "They are a breath of fresh air. I've always felt supported but they seem to want to play to our strengths. They are fantastic and I'm over the moon to be doing external training." Likewise, the registered manager told us they felt supported by the team and that initial meetings had been productive.

We found morale to be high and the culture to be one focussed on supporting people to be as independent as they were able.

The registered manager had recently taken the lead on a piece of work for the provider which mapped service provision against the Care Quality Commission's recently amended inspection methodology. This demonstrated the registered manager had a good awareness of changes within the sector. Similarly, they were keen to ensure lessons learned from the provider's other services were used to good effect at Cedars Lodge, for example introducing more streamlined care documentation.

Surveys had been completed with feedback from all people who used the service and their relatives. They demonstrated high levels of confidence in staff generally, with all respondents providing either 'good' or 'outstanding' responses regarding the abilities, skills and dedication of staff. The surveys did not ask explicit questions about the management of the service but respondents did confirm they were communicated with well in terms of content and regularity. This meant the areas where improvement was required had not at this point had a detrimental impact on people who used the service.

People who used the service were comfortable in the presence of the registered manager and assistant manager and staff confirmed they had taken a hands-on approach since joining the service. We observed the registered manager and deputy manager interacting well with people who used the service throughout the inspection.

Relatives who had spoken with the new registered manager told us they had no concerns. They confirmed, more generally, that the service had been well run in their experience, stating for example, "It's well managed and it feels like home," and, "It's well managed – they involve us by sending surveys."

Good community links were in place, for instance with local colleges. The registered manager was keen to ensure the service, and the people who used the service, did not become isolated but remained a part of the wider community. They had already made strong community links whilst registered manager of another service locally and told us they were keen to build on these links.

The office was being reorganised at the time of inspection. The registered manager and assistant manager were able to help us access records necessary to conduct the inspection. We found care records to be up to date and accurate but systems and processes relating to the management of the service, particularly auditing and the formal support of staff through supervisions, required improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not sufficiently audited and medicines administration practices were not always safe.