Pharos Care Limited

The Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 29 and 31 January 2018 and was unannounced. The service was last inspected in November 2015 and was rated as 'Good' in all questions asked.

The 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.

The Lodge accommodates eight people in one adapted building. At the time of the inspection there were eight people living at the service. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Systems were in place to ensure people were supported by staff who had received training in how to recognise signs of abuse. Staff were aware of what actions they should take if they suspected a person was at risk of harm. Where safeguarding concerns arose, they were responded to appropriately.

Staff were aware of the risks to people and how best to support them. Behaviour management plans in place provided staff with information on how to support people safely and in line with their specific needs.

Safe systems of recruitment were in place. The skill mix of staff on each shift ensured the appropriate support was available to people on a daily basis. Systems were in place to ensure people received their medicines as prescribed by their GP and staff competencies in this area were checked.

Systems were in place to protect people from the spread of infection. Accidents and incidents were reported, recorded and investigated and where appropriate lessons were learnt.

Care records provided staff with the information required to effectively support people's care, health and social well-being. Staff were supported by the management team through regular supervisions, training and team meetings. Systems were in place to monitor staff learning and ensure that staff put into practice the training that was provided.

People were supported to visit their GP and other healthcare professionals, in order to maintain good health. People were involved in planning their weekly menus and where possible, encouraged to be

involved in the preparation of their food and drinks.

Staff obtained people's consent prior to offering support. 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 receive support from caring staff who treated them with dignity and respect. People were comfortable in the presence of staff, who provided them with comfort and reassurance. People were provided with information in a format they understood.

People were supported to contribute to the planning of their care. Staff supported people in a way that took account of their individual needs and preferences.

Where complaints were raised, they were investigated and responded to accordingly and where appropriate, lessons were learned. People were confident that if they did raise concerns they would be listened to and action would be taken.

The service was considered to be well led. People, relatives and staff spoke positively of the changes in management and practice. Staff were motivated and felt supported by in their role and were on board with the registered manager's vision for the service.

People and staff were provided with the opportunity to give feedback on the service, which was then acted upon. A variety of audits were in place to assist the registered manager in driving improvement across the service.

The registered manager and staff group worked alongside other agencies in order to obtain the appropriate care and support 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.

People were supported by staff who had been trained to recognise signs of abuse and were aware of their responsibilities to safeguard people from abuse. Staff were aware of the risks to people and how to keep them safe. People were supported by sufficient numbers of safely recruited staff. People were supported to take their medicines.

Is the service effective?

Good

The service was effective.

Pre-assessment processes in place provided staff with the information required to meet people's needs effectively. Staff felt supported and listened to and received an induction and training which provided them with the skills for the job. People were supported to maintain a healthy diet and good health. Staff routinely obtained people's consent prior to offering support.

Is the service caring?

Good

The service was caring.

People were happy in the company of staff who supported them and were treated with dignity and respect. People were supported to make decisions and express their views. Systems were in place to enable people to communicate with staff in a variety of ways.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning and review of their care. People were supported to take part in a variety of activities that were of interest to them. Where complaints had been received, they were investigated and responded to appropriately.

Is the service well-led?

Good

The service was well led.

People were happy with the care they received. Staff considered the service to be well led and were complimentary of the registered manager and project manager and the changes they had introduced. Staff felt valued, listened to and supported and were motivated to ensure people enjoyed a good quality of life. There were a number of audits in place to assess the quality of the service provided.

The 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.'

The inspection was prompted in part by notification of a serious incident in which an allegation of abuse was made. The information shared with CQC about the incident indicated potential concerns regarding the safety of people living at the service and this inspection examined those risks. Prior to the inspection, the provider had notified the Police and the local safeguarding authority of the concerns and put in place measures to manage the potential risk to others.

This inspection took place on 29 and 31 January 2018 and was unannounced. The inspection was carried out by one inspector.

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 other information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths. We asked the local authority for their views about the service provided. We used the information that we had gathered to plan what areas we were going to focus on during our inspection. We spoke with three people who lived at the service and one relative. We spoke with the registered manager, the project manager and three members of care staff. Following the inspection we spoke to a social worker for two people living at the service.

We reviewed a range of documents and records including the care records of three people using the service, two medication administration records, two staff files, training records, accidents and incidents, complaints systems, minutes of meetings, activity records, surveys and quality audits.

Good

Is the service safe?

Our findings

Prior to the inspection, we were notified of a serious incident in which an allegation of abuse was made. A member of staff described how a person had made an allegation of abuse to them. They told us, "It really upset me. [Person] opened up about it. I wrote it all down what [person] said and got another member of staff in to listen." We spoke with the other member of staff who corroborated this and saw that the concerns were immediately raised with the registered manager and acted on appropriately. We saw actions were taken to safeguard the person and others living at the home and the appropriate authorities were notified of events immediately. A relative told us, "I'd rather [person] be here than somewhere else. This is the best place for [person." One person was able to tell us they felt safe and from our observations, we noted that people were comfortable in the company of the staff who supported them and were able to approach staff with any concerns they may have.

Staff were able to describe to us the individual risks to people and how they managed those risks. For example, one person had a health condition that meant they could not eat dairy products. All staff spoken with were aware of this. One member of staff said, "We record in the daily logs what [person] has eaten. They can have dairy every other day." We saw people's care records provided staff with the information they needed in order to manage risks to people. Each person had their own behaviour management booklet which identified triggers for different levels of behaviour and actions for staff to take to reduce the risk to people. Staff had received training in how to support people who may present behaviours that challenge. There had been recent changes made to the training provided to staff in this area and staff commented positively on the impact this had on people. We observed this in practice. For example, one person became distressed and paced their room. Staff remained present, but kept a distance and constantly checked on the person and offered verbal support. We later observed the person was calm and engaging with staff. This meant that the guidance staff were following in order to manage the risks to this person and themselves, was working, resulting in a positive outcome for the person.

There was a robust recruitment process in place. We saw that prior to commencing in post, the appropriate checks were made, including references and DBS [Disclosure and Barring Service] checks. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed. A member of staff told us, "It took about three months to get in here. I couldn't come in until DBS was done." The registered manager told us that an integral part of the recruitment process was asking questions regarding people's values. Staff spoken with confirmed they had been asked these types of questions at interview. Systems were in place to ensure people were supported by sufficient numbers of suitably qualified staff. We were told that there were currently two staff vacancies that were being covered by agency staff who were familiar with the home and the people who lived there.

People were supported to receive their medication as prescribed by their doctor. We observed a member of staff supporting people to take their medication. This was done efficiently but with care and thought. We saw daily audits of medication in place ensured that errors were kept to a minimum and provided the opportunity of highlighting any errors quickly. Where medication was to be given covertly, we saw evidence

of best interests meetings taking place and arrangements to review the agreement with people's GP to ensure the practice was still valid and lawful.
We saw where 'as required' medicines were given, sufficient information was in place to guide staff as to in what circumstances the medication should be administered and we noted that staff knowledge regarding people's medication was good.

We noted the monthly medication audit had highlighted additional staff required medicines training and saw this was being arranged. The registered manager told us, "Our aim is to have all staff medicines trained."

People were protected by the prevention and control of infection. We saw staff were allocated particular housekeeping duties on a daily basis and checks were in place to ensure these tasks were completed. We observed the service to be clean, but taking into account people's personal preferences when it came to keeping their rooms clean and tidy. We saw there were a number of health and safety checks in place to ensure the safety of the people living at the service, including daily, weekly and monthly audits of the environment and the equipment used at the service.

The provider told us in their Provider Information Return [PIR] that they conducted regular analysis of accidents and incidents in order to identify trends and learn from outcomes and we saw evidence of this. We saw where accidents and/or incidents took place or when safeguarding concerns arose, the information was analysed, lessons were learnt and action taken. For example, following recent safeguarding concern, risk assessments and care plans were updated to reduce the risk of the incident re-occurring. We saw the registered manager was provided with an overview of any incidents that took place enabling them to cross reference details with the person's plan of care to ensure staff followed the correct guidance. Staff were aware of their responsibilities to report concerns to external organisations such as the Local Authority, or the Care Quality Commission.

Good

Is the service effective?

Our findings

A relative said, "Staff are brilliant, I know [person] is hard work but they [staff] do a good job." We saw that people's needs were assessed in line with their health and social care needs. People's care records provided staff with a comprehensive picture of people, what was important to them, what they liked to do, when they needed support and their healthcare needs. Care plans also held information regarding people's goals, their preferences when it came to being supported by male or female carers and whether they had any particular dietary needs.

Assessments included information regarding people's daily routines. Staff understood the importance and positive impact of routine in people's daily lives. One member of staff explained how the daily allocation of support was set out to ensure people's specific needs were met. They told us, "[Person] has a certain routine and if you break it they will have a behaviour."

People were supported by staff who received an induction that prepared them for their role. We saw that staffs induction included shadowing experienced members of staff, being introduced to people living at the home, completion of an induction booklet and the care certificate. The care certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and compassionate care. A member of staff told us, "I was supported quite a lot by the team [during induction]. They have always supported me, it's the best support I've had anywhere and I support them. After induction I felt ready to go on shift and if I didn't know anything I would ask." We saw that following the period of induction, systems were in place to ensure staff competencies were assessed to ensure they supported people safely and effectively. Staff also met regularly with management, providing both parties with the opportunity to discuss their learning and concerns they may have.

One member of staff said, "All training makes a difference and we get lots of updates." We saw training provided was varied and specific to the care needs of the people who were being cared for. Staff told us they felt well trained and supported. One member of staff told us, "I'm not good with computers, I asked to go on a course and it was arranged for me."

We observed that people were supported to maintain a healthy, balanced diet. Weekly meetings took place with people living at the home to put together menu choices for the main meal of the day for the week ahead. Kitchen cupboards were labelled with pictures of food or people's names, providing people with the opportunity to purchase and store their own snacks. Photos had been taken of a wide variety of foods that were on the menu, to enable people to make choices at mealtimes. We observed one person ask each person living at the home, what they would like for their main meal of the day and showed them pictures of the choices available. They told us, "I use the picture cards because [person's name] is non-verbal." This demonstrated a family atmosphere, where people were supported to communicate with each other to create a more inclusive environment.

We saw that there were systems in place to ensure information was communicated effectively at handover and with other professionals. A local authority social worker told us, "They [management] are responding to

suggestions put forward. They are moving in the right direction and have made some progress." A member of staff said, "We all sit in handover; if we need to know anything the team leader will tell you." The details of each handover was also emailed to the registered manager on a daily basis, to provide them with a daily overview of the service.

We saw that people were supported to have regular check-ups with a variety of healthcare professionals to maintain good health. Each person had their own health care plan in place, which provided information regarding their health needs and medical appointments. Monthly reviews took place with people and their key worker and this included reviewing people's healthcare needs and ensuring they were supported to attend any appointments, for example with their dentist, GP, or optician. Staff were aware of people's particular healthcare needs and how to support them. For example, a member of staff told us, "If [person] had a seizure, one person support and reassure the person, another would monitor the symptoms, and another would make a note of the length of time." We saw for one person, regular visits were being made to get the person used to visiting the hospital prior to them having to have an x-ray to ensure the experience was as calm and reassuring as possible for them.

We saw that people's bedrooms were personalised and reflected their personality. The main lounge had photos on the wall of each person living at the home, as you would in your own family home. We noted there was pictorial signage throughout the home, to assist people in locating areas or specific items, such as the vacuum, which stored in a particular cupboard.

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 [DoLS] so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that it was.

People told us that staff obtained their consent prior to offering support and we observed this. A member of staff told us, "[Person] likes to do what he wants. He knows when he likes a shower." We saw that staff had received training in this subject and were able to demonstrate a good understanding of it and how it impacted on their practice when supporting people. A member of staff said, "[DoLS] is there to restrict a person from doing something that could harm them." The discussions we had with staff on this subject demonstrated that they were aware that decisions about people's capacity were decision specific and we saw that people's care plans reflected this.

The pre-assessment process included assessing people's capacity to make decisions regarding their daily lives. From information available and our observations, it was clear that although people lacked capacity in some areas, there was an understanding that people still had the capacity to make decisions regarding their day to day living. Staff spoken with were aware of the importance of supporting people to make their own choices and maintaining their independence where possible.

We saw evidence that prior to applications being made to the appropriate authorities to deprive a person of their liberty, meetings had taken place to ensure the actions being taken were in the person's best interests. There were systems in place to ensure the authorisations were reviewed and renewed as necessary.

The provider told us in their Provider Information Return [PIR] there had been a change in approach when it came to supporting people who may present behaviours that challenged, and we saw evidence of this. Each

person had their own behaviour management booklet in place which provided staff with details regarding what settled behaviour looked like for a person and how to recognise if a person may be agitated and how to respond to these triggers. The registered manager confirmed there had been some problems when moving over from one system to another and told us they acknowledged the process could have been managed better. A relative told us they were unsure about the changes introduced initially but said, "It's improved in the last few months, which is good." The registered manager told us lessons had been learnt from the process and overall the changes introduced had been positive. Staff spoke positively about this new way of working, which focussed on using pro-active strategies and re-direction techniques. One member of staff told us, "When it was first bought in staff were wary; but once in place, it became natural, it's less physical [restraint] and nine times out of ten you can calm someone down verbally rather than using restraint. It's a lot better."

Good

Is the service caring?

Our findings

A relative told us, "[Person] gets on well with staff. They have good relationships with staff and they trust and love everyone." They told us they could visit when they wanted and we saw that visitors were welcomed into the home. We noted that people were happy and comfortable in the company of staff who supported them. We observed many positive interactions between people and staff. Some people demonstrated their feelings towards staff through hugs and these were reciprocated. All staff spoken with, including the project manager and the registered manager, knew people well and we observed people were comfortable approaching staff and were reassured by their presence. We noted that people were spoken to and treated with kindness and respect. We observed that staff took an interest in people, passed the time of day with them and complimented them on their appearance. One person told us, "Staff are good" and another said, "[Project manager's name] is good, I can tell her anything." We noted when people returned from activities, staff enquired about what they had done and took an interest in things they had bought. For example, one person had been shopping and proudly showed everyone their purchases.

For those people who were unable to communicate verbally, communication care plans were in place which provided staff with the information required to communicate with people effectively. We saw where staff wanted to explain something specific to a person, for example, about a new activity they wanted to discuss with them, the project manager had access to a system that produced a pictorial representation of the information. These were called 'social stories' and we saw a number of examples of this around the home, including, in the kitchen, 'how to make a cup of tea'. This meant that staff were able to communicate with people regarding their everyday needs, obtain their opinions on how they wished to spend the day and effectively converse with them.

People were involved in planning their care, making decisions about their daily living and supported where possible to maintain their independence. A member of staff told us, "We try and encourage people to do their own cleaning, [person] mopped their bathroom." Another person was supported to create their menu for the week, shop for the items they needed and prepare their meals. We saw people were supported to make choices throughout the day. For example, one person had planned a particular activity but changed their mind and decided to do something else instead. Staff were available to enable the person to take part in their preferred activity in the community. We also noted that one person had been supported to cast their vote in the local mayoral elections. A social story had been created, which communicated the process to the person, providing them with the information they required to enable them to cast their vote. For those people who required the support of an advocate, arrangements would be made to access these services. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

We saw people were treated with dignity and respect. Staff respected people's choices when it came to how they looked and dressed and supported people to be individuals. Staff were able to demonstrate how they obtained people's consent prior to supporting them using different types of communication methods, for example, sign language or picture cards. A member of staff told us, "You always knock doors." We saw staff were respectful of people's private space and always asked permission if they could enter their room. When

they did this, they explained to the person the reason for them entering, for example, to administer medication or to ask permission for a visitor to come and speak to them in their room. A member of staff gave an example of how they ensured a person was helped to change into clean clothing following an incident, in private, to maintain their dignity in the home.

We noted that for one person, a sound monitor had been placed in their room to alert staff to sounds that the person was having a seizure. We were told this was mainly used through the night to provide the person with some privacy and to prevent staff from having to regularly walk into the person's room and check on them whilst they were sleeping. However, we noted the monitor allowing staff to listen in to the person's room was in a lounge area and had been left on during the day of the inspection. Although the overall sound quality was not good, people sitting in the lounge could hear what was happening and being said in the person's bedroom. We discussed this with the registered manager who assured us this would be switched off immediately and that they would speak to staff regarding this breach of confidentiality.

Good

Is the service responsive?

Our findings

We saw that people were supported to contribute to the planning of their care. The pre-assessment process involved people having their capacity assessed for a number of decisions, for example, regarding their medication, their finances and consent to care and treatment. This meant people were involved as much as possible in the development of their care plans and decisions about their daily living. Each person had a monthly meeting with their key worker to review their care and support and the activities they had been involved in and we saw evidence of this. Weekly meetings took place with people to plan the activities they wanted to take part in. We noted that people's care plans identified their needs but also their hopes, aspirations, relationships and life history. Care plans were detailed and demonstrated people's involvement by asking the question 'what I admire about me'. The language used in care records described people positively, for example, one person was described as a 'social butterfly' which we found was a good description of them.

We observed staff knew people well, knew what was important to them and knew how to hold a conversation with people regarding their particular interests. We saw that staff were responsive to people's needs. If a person wanted to change an activity, this request was accommodated. A relative told us, "Staff are very flexible; today I said I want to take [person] out to lunch as long as there are no appointments." Staff were mindful of the importance of maintaining routines and supporting people in a way that provided reassurance and helped them remain calm. For example, a member of staff told us, "[Person] has to have a countdown; they will ask how many sleeps [to an event]; it gives them more reassurance." We saw that another person was slightly agitated and staff used a number of distraction techniques to try and calm the person, for example, asking if they wanted to go and have a spray of perfume. We saw a member of staff used this distraction with an individual and the person immediately became engaged with the member of staff and went to get their perfume. These examples meant that staff were responsive to people's needs and were able to support people to enjoy their day, being involved in activities that were of interest to them.

Staff were aware of the benefits of people being able to access the community and participate in a variety of activities. A member of staff told us, "[Person]; we are trying to get them out a bit more." We saw that for this person it had been noted they had an increase in their behaviours over a period of time. This information was assessed by the behaviour manager who worked for the provider. The project manager worked together with the person's relative and social worker in order to identify additional activities the person enjoyed whilst in the community that could be achieved with the support of one member of staff instead of two. The social worker told us, "Following our meeting, they [management] have done what they said they would do." The registered manager told us, "Just because someone can't talk doesn't mean they can't make a decision. We are trying to take [person] out to somewhere they haven't been before. They will show you if they don't like it and you have then learnt something about them." We saw people were supported to take part in a variety of activities in the community, including the cinema, theme parks, bowling and specialist sensory experiences.

People told us if they weren't happy they knew they could speak to a member of staff to make a complaint. The complaints procedure was provided to people in a pictorial format to enable them to understand the

process. We saw where one person had raised a complaint, it was investigated, acted upon and a response was provided in a pictorial format to help the person understand what actions had been taken. The registered manager told us they were aware that for people who were non-verbal, it would be difficult for them to make their concerns known through the normal complaints process. In response to this, during people's monthly meetings with their key worker, analysis was done of any behaviours the person had presented during that month to see if there was an increase which may demonstrate the person was unhappy and prompt further investigation. We saw where complaints had been received they had been responded to, investigated and acted upon in line with the provider's complaints procedure.

There was no one currently at the service who was receiving end of life care. Where possible, conversations had taken place with people regarding their wishes and end of life care and information was gathered and kept under review.

Good

Is the service well-led?

Our findings

The registered manager had oversight of three separate homes. The project manager was responsible for the day to day running of the home, had been in post since September 2017. They told us of the challenges they faced when they came into the role for example, ensuring the existing staff group were on board with the changes in practice being introduced and understood the reasons why. Staff spoken with told us it had taken time, but confirmed the changes introduced had had a positive impact on the service. The registered manager acknowledged the introduction of a change in staff practice when supporting people with behaviour that challenged could have gone smoother and lessons had been learnt. Relatives did not feel fully informed at the time regarding the changes and it was felt that an opportunity had been missed to get families on board from the beginning. In response to this, the provider told us in their Provider Information Return [PIR] that they intended to introduce 'family forum' meetings with a view to gathering more information from relatives and creating a 'you said, we did' approach. The registered manager told us, "We want to get to grips with family consultation, turning negatives into positives and make sure actions are done." We saw arrangements were being made for this.

Staff told us they were on board with the changes the registered manager and project manager were introducing. We saw that efforts had been made to explain to staff the benefits of changing the way people were supported. Staff understood the reasons for change and told us they were fully on board with the new way of working. They told us the changes had bought a positive impact on people's lives at the home. A member of staff said, "It's improved, especially with [project manager's name] coming in and things have been put in place. When they first started there was not much routine around people; since [project manager and registered manager's names] have come in, it's more organised." A relative also acknowledged the positive impact the changes had on their loved one's experience of care and support at the home. We noted the project manager had a comprehensive knowledge of the people living at the service. People demonstrated that they felt safe in the project manager's company and were very tactile with them. The project manager replicated these demonstrates of affection, creating an environment of care, compassion and trust.

People were supported by staff who cared for them and shared the registered manager's vision for the service. Staff were motivated and aware of their responsibilities and described the registered manager and the project manager as supportive and approachable. One member of staff told us, "I was leaving, but [registered manager's name] convinced me to stay." Another member of staff said, "I love it here, it's like a family. There have been changes with new managers; you can speak in meetings and talk about service users and you're listened to." They provided us with an example of how they had recognised one person benefitted from activities that were sensory based and that this had been taken on board and additional activities of this nature had been sought for the person. Staff received regular supervision and we saw bespoke supervision sessions were in place to assess staffs learning following training.

We saw that as lessons were learnt, practice was changed. For example, the registered manager explained how interview questions had been developed, to ask potential staff how they thought their own beliefs may impact on how they supported people. They told us these valued based questions provided them with an

understanding of the people they employed and prevented the employment of unsuitable staff who were unable to meet the needs of the people they were paid to support. The recruitment process also included a visit to the home prior to a final offer of employment being made. This provided people living at the home and the management team, with the opportunity to meet potential new staff and observe how they fitted in with the people living at the home and the staff group as a whole. We saw that feedback was then obtained from people living at the service and staff, as to the suitability of the candidate. If it was felt the person would not fit in, they would not be offered the position. An apprentice programme was introduced with a view to providing additional staff who could support people to take part in activities in the community. The registered manager told us, "We want to provide enhanced support hours to people so that we can get people out more." Some people had a limited amount of funded hours per week that would allow this arrangement. The project manager was working with staff to be as creative as possible with staff time and banking staff hours to enable people to be supported to go on holiday.

Staff were confident that if they raised any concerns they would be listened to and were aware of the whistleblowing policy. Whistleblowing procedures protect staff members who report colleagues they believe are doing something wrong or illegal, or who are neglecting their duties.

We saw there were effective quality assurance systems in place to monitor the delivery of care provided and to drive improvement across the service. A variety of audits took place on a regular basis, the findings of which fed into a 'live' document that identified any areas for action. The registered manager had access to the document and was able to monitor performance against it. Systems were in place to share learning across all three of the services the registered manager was responsible for, including supervision session that assessed staffs competency and changes in the recording of incidents. We saw efforts were made to obtain feedback from people living at the service using a pictorial format. The responses seen were positive. All people had said they felt safe at the service, apart from one person and we saw this was followed up with the person and reassurances provided.

We saw the registered manager and project manager worked in partnership with a number of other agencies and professionals to support care delivery. We saw the service was engaging in a programme with Solihull Health Authority, of reviewing people's medication in a positive way with a view to reducing the amount of 'as required' medicines administered. The service employed their own behaviour management nurse who worked alongside the service and put together behaviour management booklets for each individual living at the home.

The provider had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.