Sunderland City Council

Blackwood Road

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

The inspection took place on 3 November 2015 and was unannounced. A second day of inspection took place on 5 November 2015 and was announced.

We previously inspected the service on 4 November 2013 and found the service was meeting the requirements of the regulations we inspected.

Blackwood Road provides personal care and support for up to seven adults with a learning disability, as well as people with a physical disability. At the time of our inspection there were seven people living in the home.

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

Staff had a good understanding of safeguarding and were confident in their role in safeguarding people. Any safeguarding concerns were investigated with outcomes fed back and practices changed if necessary in order to prevent reoccurrences. Logs and records were kept for all accidents and incidents including details of investigations, outcomes and action taken. Lessons were learnt from accidents and incidents and appropriate feedback given.

Risk assessments were in place for people where risks had been identified. There were also generic risk assessments regarding the premises and environment.

Medicines were managed effectively with safe storage and appropriate administration, reflective of the individual needs of people. All records were up to date and fully completed, with medicine audits being carried out regularly.

Staff were recruited in a safe and consistent manner with all appropriate checks carried out. Staffing levels were planned in line with the needs of each individual person. From staffing rotas we saw that staffing levels were consistent and appropriate staffing cover was readily available and used from relief and agency staff when required.

Staff had up to date training and competency assessments were carried out in relation to specific areas including management of medicine.

Staff received regular supervisions which included questionnaires on different topics. Annual appraisals were out of date for some staff members. The registered manager had a clear plan in place to bring those outstanding appraisals up to date.

The provider had created booklets that were given to all staff which covered what the Mental Capacity Act (MCA) is and the five principles all staff must follow when using the act. The back of the booklet had prompts and details in relation to the 'Speak Up' whistle blowing policy and what to do if staff had concerns.

The registered manager and staff we spoke to had a good understanding of the MCA, Deprivation of Liberty Safeguards (DoLS) and best interest assessments and these were evident within care files and DoLS authorisations were in place for every person within the home.

We observed people and staff during mealtimes. People were enjoying their meals, some independently and others with support from staff. There were choices available for people and support provided by staff was gentle and at an appropriate pace to each individual.

Communication passports were in place for each person that contained clear details of how to communicate with each person effectively. During the inspection we observed that staff followed the communication passports for individuals and responded appropriately.

Care plans were personalised, detailed and contained people's personal preferences, likes and dislikes. Care plans were up to date and reflective of each person's individual needs.

A range of regular audits were carried out by the registered manager and members of staff that related to the service the home provided as well as the premises and environment.

There was a range of activities available for people in the service. Activities ranged from sensory games, listening to music and everyday tasks to lunch outings, concerts and day trips. Staff had a good understanding of activities each individual enjoyed doing. Discussions took place during 'Tenant Meetings' in relation to activities of interest.

People's rooms were personalised and individually decorated to reflect the personalities and personal preferences of each person.

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 had a good understanding of safeguarding and were confident of their role in safeguarding people.

Medicines were managed safely.

The staff recruitment procedure was robust and consistent.

Staffing levels were planned around the people's needs. We saw people receiving care and support when required. People were supported to go on outings by additional members of staff to ensure that activities didn't impact on staffing levels required for people remaining in the home.

Fire alarm checks and drills were completed regularly. There were appropriate Personal Emergency Evacuation Plan's in place and the building was maintained with appropriate electrical and gas safety checks in place.

Is the service effective?

Good

The service was effective.

Staff had regular training and supervision to ensure they had the skills and knowledge to care for people.

The Mental Capacity Act (2005) was followed appropriately and Deprivation of Liberty Safeguard (DoLS) were authorised.

People's specific dietary requirements and nutritional needs were met. Eating and drinking care plans were in place and there was evidence of professional intervention, such as Dietician and SALT Team.

People had access to healthcare professionals as they needed them.

Is the service caring?

Good

The service was caring

Staff engaged with people in a caring and compassionate way. Care was provided in a dignified and respectful manner which appeared comfortable for people receiving the care.

Staff encouraged people's independence. They responded quickly if someone asked for support or if they noticed someone was in need of care and support.

Information was available should people require advocacy support.

Is the service responsive?

Good

The service was responsive.

The registered manager had a clear procedure in place for dealing with any concerns or complaints.

Care plans were detailed, up to date and reflected the individual needs of each person.

A range of activities were on offer for people that were suitable and appropriate for individuals and in line with their preferences.

Is the service well-led?

Good

The service was well led.

Staff told us they felt that the registered manager was supportive and approachable. They told us that they attended regular staff meetings.

A range of communication methods and quality assurance systems were in place to measure quality of the service and drive improvement. Systems were in place to learn from accidents or incidents where possible.

The registered manager and the head of care had a visible presence in and around the home.

Blackwood Road

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 comprehensive inspection took place on 3 November 2015 and was unannounced. A second day of inspection took place on 5 November 2015 and was announced.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. (Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.)

We used 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 with us.

During the inspection we spoke with two people who use the service and three members of staff, including the registered manager and two care workers. We looked at three people's care records and seven people's medicine records. We reviewed two staff files, including records of the recruitment processes. We reviewed the supervision and training reports as well as records relating to the management of the service. We completed observations around the service.

Good

Is the service safe?

Our findings

Staff had a good understanding of safeguarding. One staff member named several forms of abuse and told us they would "report to the manager" any concerns or suspicions they had. They were confident of their role in keeping people safe. Any concerns were investigated with outcomes fed back and practices changed if necessary in order to prevent reoccurrences.

One staff member told us they would "speak to the manager" if they had any concerns in the first instance but that they would speak to higher management if the felt their concerns hadn't been addressed. There was a whistle blowing policy in place called 'Speak Up' that was readily available and accessible for staff. Posters of the 'Speak Up' policy were displayed around the home for staff information to keep ensure they knew how and when they could use it.

A safeguarding file was in place which included the policy and procedure for reporting and dealing with concerns. There was a safeguarding log of concerns and alerts that had been raised, including minutes of safeguarding strategy meetings and actions taken following safeguarding issues. Records corresponded with those held by CQC.

An accident and incident file was in place which included a log of all accidents and incidents. Individual records were in place for each accident or incident as well as a record of investigations, action taken and lessons learned following any event. The registered manager informed us that accidents and incidents were reviewed regularly to identify any trends. There was a trend identified by the registered manager regarding one of people who uses the service and from this we noted relevant action, care planning and professional intervention was documented in their care records to show how this was being managed.

Care plans that identified risks to people had corresponding risk assessments and appropriate monitoring forms in place, for example, weight charts. Risk assessments were in place for each person living at Blackwood Road where risks had been identified. Risk assessments were stored within care files and were updated and reviewed in a timely manner, in line with the changing needs of individuals. All areas risk assessed linked to appropriate care plans which detailed how care was to be provided to prevent those risks. For example, where someone had been assessed as being at risk of falls, a risk assessment was in place which included any conditions, levels of mobility, equipment to be used and support required. The associated care plans covered supporting people with moving and handling, including details of equipment to be used and other support relating to their mobility.

There were a range of generic risk assessments in place relating to the premises and environment. These included a heat wave, water conditions, fire, legionella, food preparation and staff using moving and handling equipment, such as hoists and stand aids. All generic risk assessments were reviewed on a regular basis to ensure they were up to date and relevant to the service.

During our inspection we saw appropriate maintenance records for all lifting equipment. Maintenance checks were completed six monthly. The registered manager ensured maintenance checks had been

completed and identified when new checks were due to ensure maintenance was consistent.

Personal emergency evacuation procedures (PEEPs) were in place for people who used the service. These included details of each person, such as their room number and the support they required to evacuate the building. These procedures were found to be up to date and relevant to each individual. The Registered Manager explained that fire drills were carried out on a regular basis. There were records for each fire drill with details of the response from staff and people using the service. Outcomes from the drills were used to review the PEEPs in place which were updated where necessary.

Staff practiced the safe storage and administration of medicines. They understood the reasons why people needed their prescribed medicines, including when required medicines. All medicine administration records (MARs) were completed. These showed medicines were administered at the appropriate times, in accordance with people's individual prescriptions. Medicines audits were carried out twice weekly to ensure any errors in the administration of medicines would be identified more quickly. We noted there had been no errors identified in the records we had looked at.

There was a medicines file in place which contained medicines profiles for each person within the service. The profiles included their photograph, name, date of birth, medical conditions, and details of their doctors. A list of each person's prescribed medicines, including dosages, was included within medicine profiles. Staff recorded when medicines had been stopped which corresponded with the information within the care files. Photos of each type of medicine were included within the file for each individual, although a couple of the picture sheets required updating to include new medicine.

Staff administering medicines had completed level 2 external training, internal training and had passed competency assessments from both internal and external sources to ensure they were suitably qualified and competent to administer medicines to people.

The registered provider's recruitment process was followed so staff were recruited with the right skills, experience and competence. Checks were carried out for each member of staff including reference checks and a disclosure and barring service check (DBS) prior to someone being appointed. DBS checks are used as a means to assess someone's suitability to work with vulnerable people.

Staffing levels were consistent and met people's needs. Staff told us there were enough staff to meet the needs of the people and were safe but they knew more staff would be brought in if needed. During the inspection we observed that people were supervised and their needs were seen to quickly. People were given support by staff in a timely manner and a comfortable pace to each individual.

The registered manager explained that they looked at how many staff each person required to support them and meet their needs. This was how they identified how many staff were required per shift. When people had outings planned, additional staff were added to the rota to ensure the home wasn't left understaffed.

The registered manager informed us they previously introduced waking night staff but was discontinued as people's needs did not require this. The registered manager said that staffing levels were reviewed on a regular basis and would be altered to ensure people's needs were met should it be necessary to do so. There were no written records of reviews being carried out and staffing levels remained consistent from the staffing rotas we saw.

During our visit there were two members of staff were on unplanned leave and one member of staff on maternity leave. The registered manager explained that agency staff and a relief worker were covering those

hours. We looked at staffing rotas for a four week period. We found staffing levels to be consistent in numbers and roles with increased staff when outings were planned for people.

During the inspection we observed that people were supervised and their needs were seen to quickly. People were given support by staff in a timely manner and at a comfortable pace to each individual.

Good

Is the service effective?

Our findings

People were cared for by skilled and competent staff. Staff had up to date training including those deemed mandatory by the provider. Mandatory training included safeguarding adults, first aid, moving and assisting, health and safety, safe handling of medicine, deprivation of liberty and mental capacity. Additional training was available to staff members for completion including records management, freedom of information and literacy skills. The registered manager informed us that staff received training from external providers, internal sources, eLearning and topic specific questionnaires. Competency assessments were completed by the registered manager or senior care staff on staff covering a variety of areas including the administering of medicines.

Staff received regular supervision. The registered manager told us they had different questionnaires for staff to complete for each supervision session covering topics like safeguarding, medicine and moving and handling. Supervision records included discussions, developments and actions agreed, progress of which were then followed up at the next supervision session.

The provider had a policy and commitment for each staff member to receive an annual appraisal. This process involved each staff member completing a pre-appraisal form and recording and rating their individual performance over the past 12 months. The provider also completed similar forms for each member of staff. During appraisal meetings staff and the senior care worker would discuss performance, achievement and personal development. The registered manager explained that some staff appraisals were running behind due to recent changes in management and absence of staff. An appraisal matrix was produced which detailed a plan of when outstanding appraisals would take place. Outstanding appraisals for a few members of staff were behind by a couple of months.

Every person within the service had a communication passport which contained information of communication needs and clear detailed instructions of how staff should communicate with each person. Passports included details about how people could communicate. For example, that they were happy, sad, if they wanted something, didn't want something. During the inspection we observed that staff followed the communication passports for individuals and responded appropriately. They also included particular strategies to be used such as photos, pictures and objects.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager explained when they would use best interest decision forms and demonstrated knowledge of MCA and DOLS. People's care records contained best interest decisions which corresponded to the information contained in the DOLS authorisations.

A DOLS file was in place which contained an index of each person, when a DOLS application had been submitted, the outcome and if it had been authorised was recorded. Expiration dates were recorded to trigger a reminder for the registered manager to make a new application. We saw DOLS applications, authorisations and notifications to CQC were stored appropriately. All DOLS for people in the service were in date and the registered manager was able to show new applications for DOLS authorisations where they were due to expire.

Staff understood what MCA assessments were and when they should be completed. Staff also had an understanding of DoLs including what they were, when they were used and that everyone living at Blackwood Road had a DoLs in place. Further MCA & DoLS awareness training was planned to be delivered by the registered manager, to be completed by all staff. The training will include questionnaires. The registered manager explained that this was additional training to ensure staff had refreshed knowledge of MCA and DoLs.

The provider had created booklets that were given to all staff which covered what the Mental Capacity Act (MCA) is and the five principles all staff must follow when using the act. The back of the booklet had prompts and details in relation to the 'Speak Up' whistle blowing policy and what to do if staff had concerns.

People could have their lunch at a time suited to them. Although the home operates regular set meal times, for example lunch was between 12.00pm and 1.30pm, the home operated flexibly to meet the needs and preferences of individuals. One staff member told us people "can have their dinner when they want" and that when they're ready for something to eat "staff will prepare it for them". During our visit we observed one person not wanting their lunch on the lunch time and chose to eat at a later time instead. Daily menus were displayed in pictorial form in the dining room and were changed before each meal to inform people of what meals were to be served.

Staff told us people were given two options per meal time using menus in pictorial format and choices were recorded for each person. Staff explained that people would sometimes forget what they had chosen to eat and in those cases staff would prepare alternative meals taking into account each individual's personal preferences. Personal preferences, likes, dislikes and dietary requirements were recorded in a nutrition file.

The registered manager explained that if people wanted something to eat that was not on the menu, staff would make them something else of their preference. During our visit we observed people changing their minds and wanting something alternative to eat. Their wishes were listened to by staff and they were provided with an alternative meal in a timely manner.

During lunch time we observed meals being brought to people at the table in the dining room and everyone was offered a drink of their choice including juice, water, tea and coffee. We observed that some people ate their meals independently whilst others required support from staff. Staff supported those who required it, at a pace comfortable to each individual. When staff observed that people had not eaten very much they tried offering alternatives in an attempt to encourage those people to eat.

During meal times we observed the table was set nicely with napkins, cutlery and placemats. The dining room was decorated in a homely way with curtains, pictures and appropriate furniture. Food was well presented and looked appetising.

People had access to dieticians, speech & language therapists and healthcare services if needed. Records were kept of any appointments or contact with those as well as district nurses, doctors, occupational therapists, physiotherapists and chiropodists. Care files contained clear records of contact with all professionals. This included detailed involvement with a dietician for one person which was ongoing. The records were colour coded to each health condition to make notes easily identifiable.

The décor throughout the home was bright and homely with appropriate signage indicating the location of toilets, bathrooms and people's individual rooms. The lounge contained appropriate furniture as well as two specialist armchairs that had been provided for two people.

There was information and photographs displayed about the staff on duty.

Good

Is the service caring?

Our findings

The atmosphere within Blackwood Road was warm, welcoming and calm. During our inspection we saw people were happy with the care they received at Blackwood Road. People were smiling and laughing throughout the inspection and one person told us they "like living here" and that staff "were nice".

Throughout the inspection we observed positive interactions between people and staff members, such as encouraging people to join in activities or supporting them with daily tasks. We observed people receiving physical support when moving around the home or with eating and drinking. We also observed people receiving verbal support, prompting and encouragement to make individual choices and decisions where possible. For example, one person had two meals shown to them at the dining table to allow them to choose which they wanted.

Staff treated people with dignity and respect. Staff were observed knocking on people's doors and waiting for a response before entering. Staff requested permission from people before providing support, for example, moving and handling. Consent was obtained from people prior to staff members provided support.

Staff supported people gently and patiently, providing prompts and encouragement when required and at a pace comfortable to each individual.

Staff spent time sitting with people, engaging them in conversations about family members, birthdays, past stories and future events. Staff also engaged people in some individual activities which they enjoyed. The engagement observed between staff and people was positive, warm, friendly and familiar. There were lots of smiles and laughter in the dining room and later in the lounge with people interacting with each other as well as with staff.

At the time of the inspection no one required the support of an advocate as everyone had active family members. The registered manager informed us that if people did require the use of an advocate in future, they would make a referral to the independent mental capacity advocates (IMCA) and/or Sunderland People First. Information regarding those services were available within the home. Care plan files clearly demonstrated family involvement and support.

Communal areas were clean and tidy with the décor giving a homely feel. There were pictures, ornaments, flowers and an electronic photo frame in the lounge. The electronic photo frame displayed a large number of pictures of people and staff during various outings and events. The photos changed on a rotary basis. People also had free use of the kitchen area and facilities, with staff support as required.

People's bedrooms were decorated to each individual's preferences and were personalised with photographs, pictures, ornaments and other personal belongings. There was an enclosed, communal garden to the rear of the home which the registered manager informed us that people enjoyed in the summer months as there had activities in the garden, for example, a barbecue and a garden party. Staff told

us that one person in particular "enjoyed pottering around the garden" and potting plants.

Good

Is the service responsive?

Our findings

We saw people were supported to fulfil their personal preferences and choices. During our visit we observed people making decisions in relation to activities and meals. It was clear that people were in control of their care, what they wanted to do and when they wanted to do it, such as one person entered the lounge, chatted to staff and watched television then after a while went to their room to listen to music, although return to the lounge at one point and then to the kitchen to ask staff for a cup of tea.
Staff responded appropriately to decisions made by people. For example, one person decided they did not wish to take part in the activities in the lounge. They communicated this with non-verbal communication. Staff responded appropriately by moving the activity objects away from the person but continued to engage with the person to give them a sense of involvement.

People's care plans included information about their individual social interests and listed community activities they had taken part in. Community activities varied for each individual as they were personal to their preferences. These included activities such as lunches out, walks, museum visits, park visits and a trip to the Granada Studios to visit the set of Coronation Street. During our inspection a person told us they were "excited to go to Coronation Street".

A member of staff told us that they "sometimes go to concerts" with people and always had a brilliant time, with people really enjoying it. Staff spoke about people with genuine affection. They knew what different individuals liked to and had interests in.

People had a range of care plans in place to meet their needs including personal care, medicines, skin integrity, night time support and mobility. Care plans were person centred and written in the first person. People's choices, preferences, likes and dislikes were recorded throughout their care plans in relation to things such as food, activities, people and surroundings. They were detailed and gave clear directions how to meet the specific needs of each individual.

Care plans were reviewed on a regular basis during care plan audits, as well as on an ad hoc basis when people's needs changed. All care plans we reviewed were up to date and reflected the needs of each individual person.

Every person had a hospital passport form within their care plan files. These documents would be transferred to a hospital with a person should they need to be admitted. The passports, when completed, would contain all relevant and necessary information regarding an individual that would then be shared with medical professionals should people go to hospital. The passports were partially completed with all relevant personal information, personal preferences, likes and dislikes. Appropriate places left blank that would need to be completed prior to a transition to ensure information is relevant, up to date and reflective of the person.

The service had a complaints procedure that detailed each stage of a complaint and how it would be managed. The registered manager informed us that the complaints procedure was discussed during staff

meetings and staff were aware of the complaints procedure. Staff told us they know who to complain to if they were unhappy with something and "would feel comfortable" in doing so. People had a copy of the complaints procedure in their room and it was also displayed on the noticeboard within the home in an easy read format. The complaints procedure and how to complain was also discussed with people who use the service and their relatives in 'tenant meetings'.

Staff informed us that people communicated if they were unhappy with something. They were confident that family members would do the same if they were unhappy with the service.

The registered manager kept a log of all complaints received and detailed investigations that had been carried out. Outcomes of investigations and responses communicated to complainants and others concerned were also stored appropriately.

We saw that lessons learned and debriefs from complaints received were communicated to all staff during staff meetings and also meetings that had taken place with people and their family members. One complaint had been received within the last 12 months and had been investigated by the registered manager, recorded feedback had been provided to the complainant and all staff were debriefed and lessons learned shared during the following staff meeting. The complaint and outcome from it was also been communicated to people and family members during a 'tenant' meeting that followed.

Good

Is the service well-led?

Our findings

The home had a registered manager. The registered manager has been registered since 11 July 2014 and had submitted statutory notifications. Staff informed us that they felt the service was run well. They said the registered manager was approachable and supportive and they felt comfortable they could go to her with any issues or queries. The registered manager was proactive in meeting their responsibilities in relation to submitting relevant notifications to CQC. A notifications file was available to view and contained a log and copy of all notifications they had sent.

The registered manager explained that she was due to leave the home soon as she was transferring to another service within the company. The manager who would be replacing the registered manager was also present within the home during the inspection. Handovers and training were taking place between the management to ensure that when the transfer happens, the transition of managers would be smooth with minimum impact on services.

The registered manager operated an open door policy to enable and empower staff to speak to her with any queries, issues or problems. Staff told us they could go to the registered manager with any concerns or issues.

Throughout the inspection visits there was a management presence in the home with the current registered manager and the new manager both readily available for staff, people who use the service, relatives and other professionals to speak to. During out of hours, the registered manager told us that there were on call arrangements in place which included senior staff being on call, as well as Telecare being available. Telecare is an external service that provides additional care and support to people. Contact names and numbers were available in the office for staff to access as and when required.

A number of audits of varying frequencies were completed by the registered manager and staff members in relation to the service including fire safety checks and drills. These included details of fire drills and fire alarm checks carried out and the outcome of these. For example, how long it took to evacuate people from the home safely. Other audits regularly carried out related to areas such as health and safety, medication and care plans which were effective in identifying issues and required improvements. For example, medicine audits completed identified an issue with the medicine records. Appropriate action was taken and the frequency of audits were increased to twice weekly, with two members of staff checking to ensure that records were more consistent and any future errors where identified more quickly.

Questionnaires were sent out to relatives regarding the service people received earlier in the year. Responses from family members were positive saying that staff and the level of support received by people were very good. An area to improve upon was around informing relatives of staff changes. In response to this the registered manager introduced a display board in the main entrance that included names, job titles and photographs of staff. Some staff were not included on the noticeboard, the registered manager explained that the staff that were not included were agency staff covering permanent staff who were on leave.

Regular staff meetings were held which the registered manager used to raise any issues such as medicine errors and health and safety, providing updates of investigations, outcomes and lessons learned in relation to those issues. The meetings were also used to provide updates to peoples care plans as well as information in relation to developments of the service and company, for example, structural changes. During our inspection a staff meeting took place and involved the operation manager who came along to talk about company restructures and to listen to any concerns staff had.

Staff were able to share any thoughts or ideas for improvements of the service or raise anything they felt was important and wanted to discuss during meetings. Minutes were stored of the meetings that included any actions agreed.

The service held monthly 'tenant meetings' which were advertised within the home and relatives were encouraged to attend. Discussions covered a variety of topics including menu choices and activities. Minutes of meetings were available in a pictorial format and demonstrated people's views being taken into account with actions noted.

The home had a robust system in place for the daily handover of information. Written handovers were completed twice daily by the lead staff members. Handovers included information relating to each person's personal care, diet intake, appointments and any additional checks that were required during shift. Other information included repairs booked or carried out and bedroom cleaning schedules.

There was also a communication book which was used to communicate specific information to all staff. The manager explained that all staff read the communication book when they started work and that this was "normal, everyday practice".

Staff recorded appointments, day trips and outings for people in the allocated diary which was accessible to all staff. It also held details of scheduled repairs or visits from professionals. During our inspection we noted gas works and fire safety visits as well as appointments for district nurse, occupational therapist, GP and a social worker.