Care Quality Commission

Pathways Care Group Limited

Beaconhurst

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

Overall summary

This inspection took place on 5 February 2016, was unannounced and was carried out by one inspector. The provider is registered to provide accommodation and personal care for up to three people.People living at the home have a learning disability, autism and some people had additional sensory impairments. On the day of our inspection three people lived at the home.

At our last inspection in March 2014, the provider was meeting all the regulations we assessed.

There was a manager in post and she was present during our inspection. She was in the process of applying to be the 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 and associated Regulations about how the service is run.

People showed us that they felt safe in the company of staff. Staff knew how to identify harm and abuse and had been trained on how to report and protect people from harm or abuse.

People were supported to take part in everyday living tasks and to do the things that they enjoyed. The risks

Summary of findings

associated with these activities were well managed so that people could undertake these safely and without any restrictions. Staff told us their training was up to date and that they had the support that enabled them to deliver care safely. We saw staff understood people's needs and helped them to follow their chosen lifestyles and achieve their goals.

Staff supported people to remain healthy and well and to have their medicines at the right time to promote good health. Everyone had a health action plan which supported people in accessing the services they needed. People liked the food and had choices of what they ate. They were involved in the preparation of their meals and ate at the times they preferred.

People were asked for their permission before staff provided care and support so that people were able to consent to their care. Where people were unable to consent to their care because they did not have the mental capacity to do this decisions were made in their best interests. Staff worked in a way that meant people received care and support in the least restrictive way to meet their needs. The manager had considered where people's liberty may need to be restricted to keep them safe.

People had positive and meaningful relationships with staff who knew them well. We saw staff were attentive and caring towards people. Staff used people's preferred communication to ensure their individual choices were fully respected. Staff promoted and protected people's dignity and privacy while they supported people with their needs.

People's care plans described their needs and abilities and people had contributed to these. Staff supported people to follow their own daily routines and interests. Staff had supported people to express their views on the care provided and this had led to their care being tailored to meet their needs.

There was a complaints policy in place and staff were aware how they could support people to communicate if they were unhappy about something. We also saw that people had named family or representatives to advocate for them.

Regular checks had been undertaken to maintain the quality of the service. The manager had actively looked at ways to benefit the lives of people living at the home. Staffing was organised to accommodate people's lifestyles and choices. Staff had the support and training they needed to be able to understand and meet people's complex needs and promote their quality of life.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe living at the home. Staff knew how to keep people safe and had supported people with their own safety outside of the home.

Potential risks to people's well-being were well managed.

Staffing levels ensured people were safe and could enjoy their chosen lifestyle.

People received their medicines when they needed them and in a way that was safe.

Good

Is the service effective?
The service was effective.

Staff had received the training they needed to support people effectively.

People were asked for their consent in ways they understood.

People liked their meals and had been involved in menu planning to ensure that they liked the meals offered. People received support to stay healthy and well.

Good

Is the service caring?
The service was caring.

People were treated with kindness and respect by staff who knew people well and understood their likes and dislikes. Staff had positive caring relationships with people.

People's privacy and dignity was respected and their independence promoted.

People were supported to maintain relationships with their family and friends as this was important to them.

Good

Is the service responsive?
The service was responsive.

Staff were responsive to any changes in people's needs and they ensured people consistently received the support they needed.

People chose how they spent their time and were supported to follow their own recreational interests.

Staff supported people to share their concerns and people knew who to approach when they were unhappy with their support.

Good

Is the service well-led?
The service was well led.

The manager's inclusive style placed people at the centre of their focus so that everything revolved around people's needs.

Good

Summary of findings

The quality of the service was monitored and focused on enhancing the lives of people living in the home	

Care Quality Commission

Beaconhurst

Detailed findings

Background to this inspection

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

This inspection took place on 5 February 2016, was unannounced and was carried out by one inspector.

We looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of serious injuries to people receiving care and any safeguarding matters.

We asked for information about the home from the local authority who is responsible for monitoring the quality and funding of people who live there.

We met the three people who lived at the home. 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. We observed the delivery of care to people at different short periods during the day in order to lessen people's anxieties. We captured their responses throughout the day; both verbal and via facial expressions and gestures. We observed the lunch time meal and the administration of medicines. We spoke with the manager, the deputy and two staff members. We spoke with one person's family following the inspection to gather their views. We looked at the care and medicine records for three people, the accident and incident records, staff training, complaints records, and records related to the quality monitoring systems.

Good

Is the service safe?

Our findings

People showed us they felt safe in the company of staff. We saw for example throughout the day that people who lived in the home regularly approached staff and looked comfortable in their presence. We heard a person regularly seek and get reassurance from staff when they felt anxious and afraid. We heard the person say, “If I am worried about anything I should talk to staff and they will help me that’s right isn’t it?”

Staff had training and information on how to protect people from abuse. They could tell us what signs might indicate a person was being abused and about situations that could cause harm to people. Staff knew how to report any concerns if they suspected someone had been harmed or abused. One staff member told us, "I would know if someone here was communicating they were afraid, or unhappy; their body language and behaviour would indicate something was wrong and I would report it”. The manager told us they would take the necessary actions to report incidents of abuse to the local authority. We saw she had worked in an open and transparent way with the local authority when people had behaved in a way that had put them or others at risk of harm.

We heard from staff and saw throughout the day how they supported people who could present significant challenging behaviour which could include self-harm. We saw each person had individual risk assessments in place with clear strategies that staff should employ to reduce the risk of challenging situations. Each plan included input from health professionals so that the person benefitted from having appropriate support with their safety and welfare. We saw that risks had been anticipated, identified and managed. For example, the living environment enabled people to have their own facilities which enabled them to choose the amount of contact they had with each other. Aspects of the environment had been adjusted to reduce the risk of harm such as minimal objects and controls over hot water taps. This ensured that people’s safety centred on their needs, a safe environment and the expertise of staff. We heard from staff that feedback from health professionals described staff as having the expertise to manage challenging situations and keep people safe.

We saw that staff employed consistent strategies throughout the day to support people to undertake everyday activities whilst reducing risks to their safety. We saw one person make their own hot drinks and lunch with identified dangers in the kitchen being minimised such as restricting water levels in the kettle, reducing distractions and ensuring two to one staff support was available to the person. We saw staff were able to recognise the signs of extreme anxiety and knew how people communicated this. We saw staff utilised strategies to withdraw from or divert people whose behaviour was escalating. This showed there was a person centred approach to people’s individual behaviour and safety needs.

We saw staff reduce the causes of behaviour where they could by for example respecting people’s space and protecting people’s ‘structure’ so that they followed their own routines. Staff did not use restraint but had been trained in the Management of Actual or Potential Aggression, [MAPA]. These techniques equipped staff with safe physical interventions to manage challenging and aggressive behaviours. We saw on our arrival staff intervened to guide a person to a safe place by holding them, directing them and talking to them to prevent harm to us. This showed staff recognised the person’s behaviour as them communicating they were scared, unsure, or angry. The staff’s intervention ensured risks to people’s safety were managed in a consistent way.

We saw that the manager had a consistent approach to the review of people’s safety. We saw this included an analysis of accident and incident reports. There had been some minor falls and trips but no pattern or trends and these had been reviewed accordingly. Incidents had been reviewed and referred for professional assessment. The manager had systems in place to check on the safety of the premises and we saw that each person had a personal evacuation plan in the event of a fire. Nobody required the use of aids or equipment to help them mobolise.

The provider had arrangements in place to make sure suitable people were employed so people who lived at the home were not placed at risk through their recruitment practices. These arrangements were confirmed to us by the manager and staff we spoke with. There had been no new staff but we spoke with a newly transferred staff member who confirmed they had provided documents to prove their identity and a check had been completed with the Disclosure and Barring Service (DBS) before they could start working for the provider. A DBS check identifies if a person

Good

Is the service safe?

has any criminal convictions or has been banned from working with people. The staff member told us, “When I first started with the company I had to produce references and a police check before I was able to start work”.

Staff we spoke with told us they thought there were enough trained staff on duty to meet people’s needs and keep them safe. Although people could not tell us about staffing levels we saw documentary evidence that staffing levels enabled them to spontaneously go out when they wished. We saw there was enough staff to support people to participate in the routines of the day such as domestic tasks or chosen activities. We saw people's needs were met in a timely and unrushed manner. Staff were highly visible to re-direct people’s behaviours and manage their anxieties to reduce harm to their wellbeing and safety. Staffing levels were kept under review by the manager and included additional staffing where people's support needs identified this to keep them safe. On-call arrangements in emergencies were in place.

We looked at medicine arrangements and records and found these were managed well to ensure people received their medicines as prescribed. We saw the ordering, storing and checking of medicines was safe. People's medicines were clearly recorded and signed for using a Medicine Administration Record (MAR). All three people's MAR had been signed correctly and corresponded with the medicines available. Temperature charts were recorded daily and medicines were stored in line with the administration instructions to ensure people's medicines remained safe and effective. We saw that staff had received training to administer medicines. A staff member told us, “We always administer medicines in twos and we know how people prefer to take them”. We observed two staff members administering medicines and saw they checked the medicines dosage before giving this to the person. They checked with the person if they were willing to take their medicines and we saw they carried this out in a patient and encouraging manner. Some people required medicines on a ‘when required’ basis. Staff knew when people would need their ‘when required’ medicine and we saw written guidance on when to give this medicine should be given. This ensured people only had their medicine when they needed it. We saw that the balance of people’s medicines was checked daily and matched the records that allowed staff to pick up any errors quickly. We also saw that people’s communication methods had been recorded so that staff could tell from their body language or gestures if they were experiencing pain. Due to people’s complex needs they had been assessed as unable to manage this aspect of their care independently.

Good

Is the service effective?

Our findings

Our observations showed us that the support and assistance provided to people was effective in meeting their needs. We saw staff supported people to live their lives in the way that they chose and looked at positive and proactive ways of supporting people's quality of life.

We saw staff had the skills to communicate with people and had training in Makaton [a system of standard signs and hand signals] to support people's communication. We saw that staff recognised that some people's non-verbal behaviour is a communication of their need. For example we saw a person gesture and vocalise to a staff member. The staff member explained to us that repeated sounds and words indicated the person was seeking a response. We saw staff on each occasion acknowledged the person's request by moving away or giving them some space. We saw that when the level of noise increased staff recognised this as a sign of raised anxiety and redirected people to distract or calm them. A staff member told us, "It's important to recognise the visible signs that people are comfortable or not and respect they may not wish to communicate or for staff to get too close at that moment". We saw staff had the necessary skills and knowledge to support people with autism; understanding the importance of their preferences and routines.

We spoke with one staff member who had recently transferred from one of the providers other homes. They told us they had received an induction and had initially worked alongside other staff so they were supported to learn about people and their needs. The staff member told us, "I had a full induction, time to read people's care plans and understand how to manage any risks. I also understood that people living here had to be comfortable with me first so now I can see people acknowledge me more and will allow me to help them". We saw the provider had implemented the new Care Certificate to enhance their induction processes further. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people's care. There was documentary evidence to show all of the staff had a development plan and regular support. A staff member told us, "I have had great support; it can be intense but I love my work and always get guidance and support". The manager told us, "We have processes in place to support staff training and development; an induction, regular supervision and appraisals". Records confirmed that these processes were established so that staff had the skills and confidence to undertake their care role.

Staff told us they were happy with the training and support they received which had included meeting the complex needs of people with learning disabilities, autism, and behaviour that challenges. We saw that further specialist training in managing mental health conditions such as Bi-polar was planned. Staff had also completed varying levels of recognised qualifications in health and social care to a level to meet people's needs. The provider had a proactive approach to staff members' learning by ensuring staff had information and training to support their understanding of how to meet people's needs.

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 interest 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.

We found from speaking with staff they understood the principles of the MCA. We saw staff sought people's consent and accepted when people declined support. One staff member told us, "Everything we do we have to seek people's consent; we have to make sure we have explained or communicated with them and wait for their response". We saw staff were seeking people's consent by interpreting people's gestures, expressions and actions which showed them if the person agreed to the support being offered. We observed that people made their own decisions about their care; what time they got up or went to bed, what they ate, and decisions about their personal care routines. The care records we looked at showed how people were supported to direct their own care routines. Where people did not have the mental capacity to make decisions about aspects

Good

Is the service effective?

of their care appropriate family members and health professionals had been consulted to ensure decisions were made in the person's best interest. A relative we spoke with confirmed they were always involved in any decisions which needed to be made. They told us, "They (staff) consult me first and we agree together."

Staff understood it was unlawful to restrict people's liberty unless authorised to do so. We saw people's movements were not restricted and they moved around the home freely. There was a coded door but we saw people could leave the building and access the garden and go out at their request with staff support. One staff member told us, "We have one person who is at risk of trying to leave the premises and we would have to stop them for their own safety". The manager confirmed that she had taken appropriate action to submit a DoLS application for this person as they would be likely to want to leave their home without staff so this was recognised as a restriction. These actions reduced the risk of people having their everyday rights unlawfully restricted.

We saw people were supported with their nutritional needs. Menus were available in pictorial form to aid people to choose what they wanted. We saw people were supported and involved in accessing the kitchen to prepare their food. We heard staff offering choices to people, “Would you like a sandwich, cheese, you like cheese” and a person respond, “Cheese sandwich with sauce”. Staff we spoke with knew each person's dietary needs and their preferences. We saw that people chose where they ate their meals; in their own rooms or other areas of the house, there was no expectation on them and they looked comfortable with their options. One staff member told us, “People will have their own set routine of where they will eat and won’t want to socialise or communicate so we support them with this so they can eat and drink comfortably”. Records showed that people’s likes and dislikes were identified and we saw staff understood people’s preferences. One staff member said, “We know for instance that [name of person] won’t eat anything coloured red”. We heard from staff that they understood how best to support people with their meals. One staff member said, “If we present this person with small portions of their food or half a sandwich, they will eat that first then want more”. This approach worked well as we saw that people received the individual support they needed with their meals. Mealtimes were flexible to accommodate people’s routines and preferences and we saw that people had their breakfast and lunch at times to suite them. We saw that staff were vigilant when supporting people at mealtimes and in the vicinity of the kitchen.

Each person had a pictorial Health Action Plan [HAP] which provided up to date information on how they expressed pain, how their health needs were met, by whom and the frequency. The HAP had been used during a recent hospital stay for one person in order to provide information to health professionals about the person, their communication and their health history. We saw preventative healthcare action was in place with external professionals who supported people with their health needs, this included regular reviews of their medicines and emotional health.

Good

Is the service caring?

Our findings

In all of our interactions with staff we found that they consistently spoke about and referred to people in a caring, positive and respectful way showing they had a high regard for people they supported.

We saw staff assisted and supported people in a kind and caring way. We observed that staff always acknowledged people's attempts to communicate, verbally or non-verbally and we saw that they responded to people with signs and gestures as well as words in order to aid the person's understanding. A staff member told us, "Communication is key". We saw staff consistently listened to people and checked their own understanding by repeating back to the person to establish what they wanted. We saw that this approach visibly calmed people because they became less vocal and animated in their gestures. This showed us that staff understood the importance of reducing the level of people's frustration.

We saw that staff had a caring, person-centred approach because they put the person first before the task. For example one person exhibited specific behaviours but we saw staff understood what these behaviours were communicating. For example, 'I don't want to see you' and waited before entering the person's room. This showed staff did not work in a task-led way but in a way that allowed them to take practical action to relieve people's distress or discomfort at a time that suited the person.

We saw several examples of where staff tried to reassure people that they mattered. For example there were many occasions where staff spent time with a person to listen to them, talk with them and try to alleviate their anxiety. A staff member told us, "It's important to understand what can comfort people because physical contact may not be their preferred method". We saw staff knew how to comfort and manage people's distress because this had been explored and recorded in their care plans. For example we saw that for some people they responded to going through their 'life book' looking at pictures and remembering events, other people responded to music.

We observed that people were supported to express their views about their daily living arrangements and lifestyles. We saw one person preferred to be supported by male staff and this person responded to this arrangement. We saw people were involved in decisions during the day with choices being offered to them about what they ate, where they ate and how they spent their time. One person was supported every day to go to the local shops to purchase items he favoured. A staff member told us, "This is his routine and something he loves and we respect that". We saw some people were involved in daily chores which helped to promote people's independence and autonomy. We saw staff enabled people to engage in these daily tasks in a safe and controlled manner and in a way they were comfortable with. For example by ensuring they had one to one support and did not have to come into contact with other people if this raised their anxieties.

People showed us they were happy and confident to approach staff either through speech, by vocalising, or via the use of touch or gesture. We saw that staff responded to people's greetings in a warm and friendly manner. Staff interpreted people's body language and behaviour and knew when people were becoming anxious. We saw staff provided reassurance to reduce people's anxiety.

People's privacy was promoted and we saw that their choices and needs had been explored and respected. Each person had their own living quarters which included a lounge, bedroom and bathing facilities. This enabled people to have the privacy they wanted and we saw people preferred to stay within their own personal space. Arrangements were in place to support people with their personal mail, bank accounts and finances. Staff were able to describe to us how they sought input from advocacy services to represent people's interests where they were unable to do this for themselves. We saw that the services of an advocate had been considered and recognised to represent one of the people regarding their finances.

We saw that some people due to their complex behaviours needed support to protect their dignity. We saw throughout the day that staff had strategies in place to protect people's dignity and used these effectively. We saw staff promoted people's self-esteem by for example complimenting people on their appearance. We saw for instance that one person had a low tolerance of clothing but when the person remained dressed staff praised them for this. This showed that staff recognised the achievements of people.

Good

Is the service responsive?

Our findings

Our observations showed that people received consistent care and support that was responsive to their individual needs. Relatives we spoke with confirmed that they were asked for their views. A relative said, “[Person’s name] is getting the right care, we are very happy they look after [person’s name] very well”.

We saw that the day was organised around people’s individual needs and that people had support in a way they needed. People’s needs and choices had been identified with them both verbally and through non-verbal communication such as their behavioural response to routines. We saw staff knew people's needs well. A staff member said, "Everybody has their own preferences and routines and it’s very important to them that they follow these”. We saw examples of this where people’s routines in the day were specific to them; the time they got up, how their personal care was carried out and by whom and what they ate.

We saw people’s care plans were personal to them, descriptive and had considered their complex needs in relation to conditions such as autism, epilepsy, behavioural needs and mental health needs. Staff were able to describe the warning signs of escalating behaviour and the strategies to be used to diffuse situations where people may put themselves or others at risk of harm if they became anxious or distressed. Staff were able to tell us how they managed epilepsy and we saw guidelines were in place in the event of a person experiencing a seizure and how a seizure was to be responded to by staff.

We found that continual assessment of people’s needs and consideration of people’s autism and diversity was evident. For example environmental factors that can influence people’s behaviour had been taken into account. We saw for example people lived alongside their peers but had the facilities that ensured a reassuring environment for them because they did not have to comply with communal living arrangements. This meant people were able to feel ‘secure’ and their anxieties could be reduced. A relative said, “The smaller living arrangement works much better, [name of person] is doing very well; happy and settled”.

We saw each person had a structure to their day based around their preferences which met their needs for a degree of ‘certainty’ and ‘control’ over their day. We saw that staff took positive action to ensure people’s goals and wishes were being addressed. People were seen to direct their daily activities; choices were offered and we saw staff responded to the things people wanted to do. For example one person enjoyed a daily shopping trip to purchase magazines and enjoyed this opportunity. Another person was regularly supported to see their family. We heard from their family that this was a major achievement and one that they welcomed which ensured the person was supported to maintain relationships that were important to them.

Some spontaneous activity also took place which had included visiting places of interest, trips to the seaside and a holiday in a bungalow. We heard one person communicate to us, “Bungalow, bungalow” whilst holding a blanket that represented their trips to the bungalow. The person was clearly communicating this was an event that they enjoyed. We saw there was flexibility in order to accommodate people’s wishes if people wanted to go out for a walk or a drive. Each person had access to their own transport which enabled people to access places more easily. We saw activities and pastimes focused on each individual who led the way in what they wanted to do. For example there were opportunities for people to listen to music, DVD’s look through books and engage in a regular keep fit session provided by an external coach.

We saw that staff regularly reviewed people's needs with them by asking them or observing their response to the support delivered. Appropriate external specialists were involved and we saw their recommendations contributed to the way staff worked with people. The well-being of each person was documented in daily notes. These recorded each person's activities, their behaviours and communication and provided an overall picture of the person's wellbeing. Staff told us they handed over information at the end of shifts. One staff member told us, "We share information about people’s needs so that we can be consistent and respond to any changes”.

The complaints procedure was available in a format people could understand. However, some people at the home would be unlikely to be able to make a complaint due to their communication needs and level of understanding. Staff were aware of the signs to look for if people were expressing they were unhappy about something and told us they would address this. A relative told us they had no complaints and had, “Every confidence in staff”. We saw that people's care plans contained information about how

Good

Is the service responsive?

people communicated if they were unhappy about something. We also saw that people had named family or representatives to advocate for them. There was a complaints process for receiving and responding to any complaints. There had been no complaints made about the home.

Good

Is the service well-led?

Our findings

All the people we met indicated they knew and liked the manager. A relative told us, "The manager is very good, she's only been there a short while and we were worried but it is much more relaxed". Staff told us they were confident that the manager would support them in all aspects of their work. A staff member told us, "She's really been great; can talk to her any time, she puts people first and works on the floor with us".

The manager had been in post since May 2015 and told us they were in the process of applying to be registered with us, the Care Quality Commission (CQC) as is required by law. A leadership structure was in place which included a deputy and external line manager. We saw the manager actively had daily contact with people and worked alongside staff on a daily basis. We observed that all of the people clearly knew and 'accepted' her showing they had a positive relationship with her. This was evident because we saw that people reacted in an animated way when she was present; vocalising or talking with her. We saw she was inclusive in her approach; she proactively engaged with people in a way they understood.

We saw the manager and staff team promoted a person-centred approach to people's care needs. She had a clear set of values which we saw that staff understood and put into practice. This was evidenced by the positive interactions we observed between staff and the people they supported. We saw a high level of involvement of people in their own care; for example people directing their own routines for the day. There were no rigid routines and people had flexibility and control around when they ate or got up and what they did. A staff member told us, "We focus on what people need and want and the manager supports us to do that".

We saw people were involved in how the home was run in a way that was meaningful to them. For example staff demonstrated an understanding of equality and diversity and put this into practice by supporting people to make their own choices about their everyday opportunities and to say what they wanted or liked. These values had been used to shape the delivery of people's care. For example staff ensured all aspects of people's care such as their dignity, independence, safety and life choices were respected. We saw people were the central focus and everything revolved around their needs. Staffing levels ensured that people had the support and supervision they needed to keep them safe and get the support they needed to enjoy their choices.

The provider had ensured that the views of people living in the home and their families. had been regularly sought via surveys. The results of these told us that people were very happy with the care provided. We saw correspondence in people's care files where external professionals had made positive comments regarding how the home was managing people's complex needs. Relatives told us of positive outcomes for individual people. We saw that people's views had been sought through regular meetings so that people could say what they wanted and action to meet requests had been taken such as providing an annual holiday of people's choice.

Staff were aware of whistle blowing procedures and how to report concerns about the conduct of colleagues or other professionals. Staff were confident that the manager would support them with any concerns. A staff member told us, "There have been so many positives since the manager started here; it's more relaxed, people have more choices and staff get so much support and guidance". We saw that staff were highly motivated, received the training and support they needed to meet people's needs and they worked extremely well as a team. Staff reported they loved working in the home.

Services that provide health and social care to people are required to inform the the CQC, of important events that happen in the service. The manager was aware of this requirement. The manager had kept themselves up to date with new developments and requirements in the care sector. Our discussions with the manager showed she was aware of the new Care Certificate and had introduced this with new starters to improve the induction process.

Quality assurance and monitoring of the home was established and carried out both on a daily basis and via regular audits. Records showed the provider visited the home on a regular basis to monitor, check and review the standards of care. The provider had updated the kitchen area providing a better environment for people to use. We saw that the manager had proactively focused on the needs of the people within the home and as such had

Good

Is the service well-led?

identified further specialist training for staff to make sure they continued to be effective in meeting the needs of people. This included training for staff on mental health and Bi-polar.