Dimensions Somerset Sev Limited

Dimensions Somerset The Old Vicarage

Inspection report

The Old Vicarage
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Tel: 01278653688

Date of inspection visit:
20 April 2018
24 April 2018

Date of publication:
31 May 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 and 24 April 2018 and was unannounced. This is the first inspection for the location under this new provider.

Dimensions Somerset The Old Vicarage 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.

Dimensions Somerset The Old Vicarage accommodates up to seven people in one adapted building. At the time of the inspection four people with learning disabilities and other complex needs were living at the home. None of the people were able to verbally communicate with us. Their opinions were captured through observations, interactions they had with staff and their reactions. Each person has a personalised bedroom and there were communal spaces including a kitchen dining room, lounge and sensory space. There was a garden and people were free to move around the home if they were able to.

"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". Registering the Right Support CQC policy

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

People were happy and appeared comfortable in the presence of staff. Their relatives thought people were kept safe. Improvements could be made with the management of medicines because practice was not always in line with current national guidance to keep people safe. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. Not all health and safety checks were being completed due to staff changes.

The management had developed positive relationships with people, their families and other professionals. There were enough staff to keep people safe and due to recent changes sometimes activities had to be adapted to the number of staff. Recruitment systems were in place to reduce the risk of inappropriate staff working at the home.

People were protected from potential abuse because staff understood how to recognise signs of abuse and knew who to report it to. When there had been accidents or incidents systems were in place to demonstrate lessons learnt and how improvements were made. Staff had been trained in areas to have skills and knowledge required to effectively support people. People had their healthcare needs met and staff

supported them to see other health and social care professionals

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible. When people lacked capacity decisions had been made on their behalf following current legislation. People were supported to eat a healthy, balanced diet and had choices about what they ate.

Care and support was personalised to each person which ensured they were able to make choices about their day to day lives. Care plans had a wealth of information about people's needs and wishes which occasionally could become confusing. People were listened to when they were upset and their relatives knew how to complain. There was a system in place to manage complaints.

Relatives told us, and we observed, that staff were kind and patient. People's privacy and dignity was respected by staff. Their cultural or religious needs were valued. People, or their representatives, were involved in decisions about the care and support they received. People were supported to have an incredibly dignified death and there were positive links with the local hospice.

The service was well led and shortfalls identified during the inspection had mainly been identified by the management. There was a proactive approach from the management and provider and additional scrutiny was being sourced from external agencies. The provider had completed statutory notifications in line with legislation to inform external agencies of significant events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

People were not always having their medicines administered in line with current national guidance.

People were protected from risks because care plans contained guidance for staff and risk assessments were in place. Improvements could be made with how some health and safety was managed.

People were protected from the risks associated with poor staff recruitment because a recruitment procedure was followed for new staff.

People had risks of potential abuse or harm minimised because staff understood the correct processes to be followed.

Is the service effective?

Good

The home was effective

People were supported by staff who had the skills and knowledge to meet their needs.

People had decisions made in line with current national guidance and relevant representatives were consulted.

People had access to medical and community healthcare support because there were strong links with them.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Is the service caring?

Good

The home was caring.

People were able to make choices and staff respected their decisions.

People's privacy and dignity was respected by the staff.

People were supported by kind and caring staff who knew them very well.

People were able to exercise their religious and cultural beliefs.

Is the service responsive?

Good

The home was responsive.

People's needs and wishes regarding their care were understood by staff. Care plans contained a wealth of information to provide guidance for staff.

People benefitted because staff found ways to undertake activities even with changes occurring.

People were listened to when they were upset. Relatives knew how to raise concerns and there was a system in place to manage complaints.

People were supported to have a very dignified death.

Is the service well-led?

Good

The home was well led.

People were supported by a management who made changes to systems when they identified things could be improved.

People were using a service which had clear scrutiny to ensure they were receiving care and treatment in line with their needs.

People and their relatives were involved in decisions about how the service was being run.

People benefitted from using a service which had staff who felt supported most of the time and worked as a team.

Dimensions Somerset The Old Vicarage

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 20 and 24 April 2018 and was unannounced.

It was carried out by one adult social care inspector.

The provider had completed a Provider Information Return (PIR). The PIR 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 spoke with other health and social care professionals and looked at other information we held about the service before the inspection visit.

We spent time with four people living in the home and made observations. We spoke with the registered manager and four members of staff. Following the inspection we spoke with two relatives on the telephone.

We looked at three people's care records in various depths. We observed care and support in communal areas. We looked at three staff files, information received from the provider, staff rotas, quality assurance audits, staff training records, the complaints and complements system, medication files, environmental files, statement of purpose and a selection of the provider's policies.

During the inspection we asked for further information including quality assurance documents and training records. Following the inspection we asked for clarification on one person's medicine administration. We received all of this information in the time scales given.

Requires Improvement

Is the service safe?

Our findings

Although relatives felt their family members were safe we found improvements could be made around medicine management, health and safety and fire safety. One relative said, "I think [they] are very safe. No safety hazards or anything".

People did not always have their medicines managed in line with current best practice to reduce the risks of potential harm. Staff knew people's preferences and administered their medicine in line with these. People's medicine was stored securely in their bedrooms. One person required their medicine administered mixed in their food or drink. There were guidelines of what staff should do and staff were all aware. Improvements were required for the records relating to which health professionals had been consulted prior to this practice. No guidance was in place for topical creams and where they should be applied for each person. Neither was there guidance in place for how variable doses or 'as required' medicine should be administered. Whilst most staff knew people well there were new staff. This meant there was a potential risk people would not receive medicine as prescribed or consistently. The registered manager showed us work that had already begun on creating further guidance for 'as required' medicine.

One person took their medicine with a spoonful of yoghurt. This practice had not been checked with a pharmacist to ensure it would not damage the effectiveness of the medicine. Following the inspection we learnt the person now took their medicine with a drink instead. The registered manager had liaised with the pharmacist. Two bottles of liquid medicine had no information about when they were first used. This meant there was a risk they could be less effective or unsafe to use. The registered manager immediately took them to investigate. We found one person had a left over dirty spoon and pot potentially containing medicine left in their bedroom. There were people free to move around the home including the person whose bedroom it was. No one had accessed this left over medicine. The registered manager immediately removed the medicine pots and spoon. They told us they would communicate the importance of not leaving left over medicine pots unattended to staff.

Most health and safety risks had been considered. There were regular checks to ensure hoists were safe and well maintained. During the inspection one person's specialist wheelchair was maintained by an external agency. Windows had safety film and restrictors to reduce the likelihood of injuries to people. An annual water quality check for legionnaires had been completed. Improvements were required for more routine water checks including the flushing of water in unused places. The registered manager informed us the member of staff who used to be responsible for overseeing the health and safety had left. Recently, a new member of staff had been allocated with the responsibility and they are putting new systems in place. During the inspection the registered manager identified some additional training for this member of staff.

There were systems in place to keep people safe in the event of a fire. Fire alarms, emergency lights and fire extinguishers were regularly checked by staff. A grab file was in place near the front door to the home. This contained important information in the event of a fire to inform the fire brigade of details of people and the home. It also had key information for who should be contacted by the staff. Improvements were required to ensure the most up to date information was contained in this file to prevent harm to people and others in

the event of a fire. During the inspection staff updated this information.

People were supported by enough staff to meet their needs and keep them safe. Since the change in provider there had been some staff losses at the home. Many of the remaining staff had worked at the home for years. This provided consistency for the people whilst the changes were happening. Additionally, staff had a detailed understanding and knowledge about the people's needs, preferences and wishes. The registered manager had worked shifts to help when there had been a shortage of staff through the transition. They also told us there had been a use of consistent agency staff when it was required. When there was no management present there was a senior on call system in place. This provided support for staff when there was an emergency. However, there were times because of staff changes the activities were limited for people. This was because the amount of staff it took to operate the minibus safely. The registered manager told us recruitment was ongoing and there were plans to have a different bus which would need less staff to operate it.

People were kept safe because there was a recruitment system in place. All members of staff were being required to have new checks to ensure they were safe to work with vulnerable people. New staff had full employment history, references from previous employers and criminal record checks. Members of staff were able to tell us what checks they had been through when they first began working at the home. No staff had begun work prior to the checks being completed.

People were kept safe because risks had been assessed and ways to mitigate them found. There was a focus on maintaining as much independence as possible. There were a range of risk assessments for pressure care, mobility, eating and drinking and accessing the community. When people needed transferring there were clear guidelines about which type of sling and hoist should be used. One person needed additional support following a serious accident. The risk assessment in their care plan highlighted these additional precautions staff should take. All staff we spoke with were aware of what the risk assessment said.

Risks of the spread of infection were minimised because there were systems in place. Every person had individual hoist slings. Staff wore gloves and aprons during intimate care. Prior to preparing food staff washed their hands. The home was clean and there were schedules in place to ensure all areas were cleaned. One member of staff explained, "We always involve them [meaning the people] with cleaning" because it is their home. Night staff would ensure wheelchairs and hoists were cleaned after each day.

People who could become anxious and display behaviours which could distress themselves or others had systems in place to support them. One member of staff informed us the provider now had a specialist they could refer to if they were concerned about a person's behaviour. During the inspection one person became anxious and we saw staff knew exactly what to do to support them. They took them out on a long walk and removed them from the situation which was causing them distress. Staff were mindful that all the changes in staff had led to some people becoming more anxious. They were aware when new staff were going to start it would take some time for them to become comfortable. The staff rota demonstrated staff combinations had been considered to ensure there were some familiar staff working with people.

People were kept safe from potential abuse because all staff were aware of how to raise concerns and recognise signs. One member of staff said, "If it is serious I would report to [name of registered manager]". Another member of staff told us they would look out for bruising, change in personality and if the person was nervous around them. All staff agreed if they raised concerns to the management it would be resolved. They all knew which external bodies they could report their concerns to if they were still worried. Every month the provider would review the safeguarding raised on the system to ensure any patterns were identified and acted upon.

The provider and management took accidents and incidents seriously. They strove to learn from any which had occurred to prevent people or staff getting harmed. When accidents or incidents did occur they demonstrated how lessons had been learnt and actions taken to reduce the likelihood of a repeat. For example, there had been an incident involving a mobile hoist. It became stuck on a section of the bed causing it to become unstable and potentially risk harm for staff or people. In response, a new risk assessment and guidelines were put in place. Additionally, an overhead hoist was purchased for one person's bedroom so the mobile hoist would no longer be used. The provider organised the internal health and safety specialist to come and review the actions taken by the management at the home. By having a robust system for any accident and incident people were being protected by lessons being learnt.

Some incidents and accidents had been identified by the provider as 'never events'. For example, if a person was injured by a member of staff. If any of these events did occur there was a clear reporting system in place. It would lead to a 'never event panel' which would then identify any improvements which immediately needed to be made. This would lead to working practices changing and communicated through operational meetings. Additionally, there was a team manager's brief which contained important information including outcomes from these meetings to makes sure any learning from such events was shared to improve practice and outcomes for people.

Good

Is the service effective?

Our findings

Staff involved people as much as possible in preparing their meals. One relative told us their family member was taken by staff into the kitchen to help prepare their food. During the inspection we saw people being involved as much as they could. One person sat and watched whilst a member of staff prepared their lunch. The member of staff was talking them through what they were doing. The person was clearly engaged in what was happening.

People were supported by staff who knew their eating and drinking needs and preferences. One person had their breakfast served one spoonful at a time into another bowl. This was a new system put in place to prevent choking whilst they were eating. All members of staff were aware of the special diets each person required. This included thickened drinks and softened food to prevent them choking or aspirating. There was regular contact with the speech and language therapist to ensure people were receiving safe food and drink.

Breakfast and lunches were individualised so each person could select what they wanted. Staff knew people's preferences so could provide them with choices in line with this. At dinner time there was one main meal prepared for all the people to eat. Variations of this meal were created so they were in line with people's specialist diets. Staff told us if a person indicated they wanted something else or refused the food they would offer something else.

People were supported to see a variety of health and social care professionals to support their complex needs. One relative told us they were always kept informed about any medical appointments and changes in their family member. One person had recently been to the hospital to have a review of their feet. Other people had seen chiropodists, physiotherapists, dentists and speech and language therapists. All people had annual reviews with their GP in line with current best practice. When people had significant health conditions they regularly met with specialists to monitor them. For example, one person with epilepsy had routine appointments with an epilepsy nurse. Their consultant would review their case periodically to ensure all the medicine was working effectively.

Staff had developed strong working relationships with other health and social care professionals to ensure people's complex needs were met. One member of staff said, "We have a good relationship with the GP". They continued to explain the registered manager had a meeting with the surgery and practice manager to develop this relationship. Another member of staff spoke about their relationship with the speech and language therapist who would respect when they raised a concern about a person. One member of staff told us, "We get good feedback from other professionals". This meant when staff worked well with other professionals to maintain people's health. For example, one person became very tired so staff alerted the health professionals. After a number of tests it was identified the person had a health condition. Staff worked with the doctors to improve the person's health. They no longer required the additional medicine.

People living in the home were able to make some basic choices themselves with the support of staff. They would be offered objects to choose from or a choice of clothes. When there were significant decisions many

people lacked capacity to make it on their own. 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.

We checked whether the service was working within the principles of the MCA and found people who lacked capacity to make important decisions had them made in line with current legislation. Staff knew about needing to make a decision in the person's best interest. One member of staff said, "We do a best interest and capacity assessment for every task". Staff and the management were recognising when things to keep people safe were restrictive practices. The registered manager had recently been consulting with people's relatives and other professionals to arrange consent and best interest meetings. For example, one person required a wheelchair lap belt, bed rails and a listening device at night. Consent and best interest meetings were being gained from those important to them.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These had been applied for all people living at the home because they were all monitored closely by staff and unable to leave the premises alone. None of the DoLS had been authorised by the local authority. The registered manager told us they liaised with the local authority to find out the progress.

Staff were provided with training which gave them the skills required to meet people's needs. The provider matched training to people's specific care needs to make sure people were effectively supported by staff. One staff member said they had recently completed a specialist eating and drinking training course. Most staff had received medicine management training. The registered manager told us two new staff were undergoing it at the moment.

Staff told us they were experiencing a cultural change about how training was being delivered. There was now an emphasis on computer based training rather than face to face. One member of staff informed us they would, "Prefer to be in a training room". They continued to tell us some training still was. This included moving and handling, basic life support and positive behaviour support. Members of staff and the registered manager were positive about the greater range of training which was accessible.

Most staff had completed the induction set up by the provider. This was so they could learn new systems and refresh their knowledge. Many of the staff currently working at the home did not need to complete the Care Certificate because they had been working in care for a long time. The Care Certificate is a nationally recognised standard to make sure all staff working in care has basic skills to look after people. Systems were in place for when new staff started to undertake the Care Certificate to ensure they had understanding of how to support people.

The provider had created alternative ways of training for senior staff. There was more online interactive meetings and sharing of new information. The registered manager was positive about these changes because they were able to learn about different specialists within the provider. They were also introduced to the new systems which were being implemented. For example, the systems for reporting accidents, incidents and safeguarding had become more robust. A senior member of staff had been talking them through expectations and responsibilities of each person at each stage.

People's bedrooms were customised to meet their hobbies and interests. One person had pictures of cows

in their bedroom. When bedrooms were redecorated people were involved us much as possible. They had been shown colour options they could point at. One member of staff told us because one person had moved to a different room they were still waiting to paint it. Despite this there had been personalisation to make it feel like the person's space. The person had a mini-library to store their books and car pictures all around the walls.

Care plans contained information to demonstrate and celebrate their differences. They gave guidance to staff about how to adapt their interactions in line with these. For example, one person had information about how staff should communicate with them and offer choice. Staff had built links with the community to embrace people's different views.

Each person had health action plans in line with current national guidance. This included a 'hospital passport' which provided key information for when they attended hospital. The passport contained information such as eating and drinking needs, medicine they were on, mobility needs and communication methods. By having this it provided other professionals with important information on how to support the person. There were occasions when some national guidance had not been followed. For example, information from the National Institute of Clinical Excellence around medicine management. The registered manager informed us they would be referring to it to update the medicine practice in the home.

Good

Is the service caring?

Our findings

People were cared for by a relatively stable staff team who knew them well and always showed compassion and kindness. The people were comfortable in staff presence and at times sought out staff to interact with them. We saw lots of laughing and smiling between people and the staff. When one person moved to engage with a staff member and try to communicate the staff member immediately knew the person wanted to sing. They started to sing one of the person's favourite songs and the person tried to join in.

One relative told us, "The girls [meaning the staff] are very thoughtful and kind" and continued, "They look after [name of person] marvellously". Another relative said, "It is absolutely marvellous. Staff are helpful and friendly" and continued, "Staff look after [them] very well". One member of staff said, "It is a lovely environment. Warm and friendly". The registered manager wanted to make sure all people were supported by kind and caring staff. They were appreciative of the staff team they had to support the people.

People were offered choice and staff respected it. One person was asked which flavoured drink they would like. The member of staff waited for them to think about it and then select one using eye pointing. This was the drink which was then prepared for them. Another person was presented with objects to choose from and once they had made their choice the staff supported them. One relative said, "They [meaning the staff] give all the choices [the person] needs". Choices were offered in a way people could express their choice. This could be pointing at objects or using eye pointing.

People had their privacy and dignity respected by members of staff at all times. One relative said, "They [meaning the staff] are very good. Keep [them] clean and fresh. Never find [them] dirty or untidy. Always smelling nice". One member of staff said, "I always knock on the door" and during intimate care they made sure people are covered. Other staff clearly knew how to deliver intimate care in a way which respected the person's privacy. Staff always accompanied the person to their bedroom so intimate care was in private. One member of staff identified a person had a dirty t-shirt after eating. They immediately told them discretely they would go and help them change. A short while later the person returned to the room with clean clothes looking happy.

People's cultural and religious beliefs were respected. The staff had developed links with the local church for one person. Every Sunday some volunteers would meet the person at the home and take them across to the church service. To develop this link staff had begun by shadowing the volunteers and the management had provided guidance for them. The person enjoyed singing along to the hymns and socialising with the congregation. After the service they would return to the home. At Christmas the person would attend the church to celebrate with others.

People were supported to remain in contact with their family and friends. One member of staff said, "We do have a good relationship with all their families". One person's family was unable to visit as regularly any more. The staff and management had arranged for a taxi to bring the family member to the home every six weeks. The relative was pleased with this arrangement because they used to visit all the time. Another relative told us they would, "Call unexpectedly" and there was no problem with this.

Good

Is the service responsive?

Our findings

People participated in activities whilst living at the home. Recently, these had included more in house and local options due to staff shortages. One relative said, "They used to do a bit more" and informed us the person had been to horse racing and local sites. One person showed us their books they enjoyed reading with staff. Another person went for a walk with a member of staff during the inspection. They came back smiling and enjoying when the staff member recounted the animals they had seen. One relative explained they had received a Christmas card created by their family member with the support of staff. They were touched by this idea. During the inspection an entertainer came to sing with the people. Three people were smiling, rocking and joining in. One of the people did not like to participate in the entertainment so they went out with staff to a favourite place locally.

Other activities had been carried out which were designed around people's interests and hobbies. One person went to a disco with members of staff. There had been a visit from a therapy miniature horse and one person had a trip to a local seaside resort. Staff wanted to do more activities in the community. They were looking forward to when staff levels were resolved or a different minibus was sourced. One member of staff said because of staff levels there was not always activities for people. There were times when basic needs had to take priority such as supporting people with intimate care.

Peoples care plans were personalised and considered their needs and wishes. There were sections on different areas of their life. This included communication and mobility needs; eating and drinking support; health needs and life history. Staff were familiar with them and knew about people incredibly well. Sometimes people's care plans had a large amount of information for staff to refer to about their care. At times this could become overwhelming and confusing because information began to contradict each other. Although the care plans were a little out of date or confusing in places staff knew people and their needs. There were times there was new staff or agency staff who may need to rely on this to support people. The registered manager told us they were in the process of reviewing the quantity of paperwork contained in each care plan. During the inspection one person's care plan was updated so more historical information was archived.

People's needs were regularly reviewed by staff informally and formally. One relative said, "I have gone down when they have reviews. Usually sent me a report". They continued to say, "There has not been a review recently". When there were changes to people's needs action was taken. One person's mobility needs had declined so they needed more support with transfers between places. This included the use of specialist equipment. In response the staff had consulted with them and their family about moving to a bigger bedroom. It was all agreed and the person was now happily in a larger bedroom. Another person's mobility needs had changed. Staff had sourced an assessment from a health professional and a new range of equipment was now in place to support them with transfers. Records did not always reflect the actions taken by staff. The registered manager accepted due to staff levels this was an area for improvement they would work on.

People were supported to have an incredibly dignified death in line with their wishes and needs. Strong links

had been developed with the local hospice. All staff had recently received training in end of life care with the hospice staff. Some of the staff completed more in depth training and support to assist them providing high quality care for a person nearing the end of their life. One member of staff told us, "When his [meaning the person's] healthcare needs changed having support and reassurance at end of the phone was valuable". They continued the registered manager was always at the end of a phone even when not at the home. Since the person passed away the staff have been involved in some research by a learning disability nurse to find out what went well and what could have been improved. The nurse had praised the team for their approach when supporting the person.

The registered manager told us their aim for people was to keep their promise if people wanted to stay in a place they knew at the end of their life. They told us although it was distressing for staff at times it had a, "Very positive outcome" for the person. The person was able to stay at the home until just before the end when they needed to move to hospital. To keep consistency staff remained with them 24 hours a day in the hospital until the end. The registered manager said, "Staff rose to the occasion". They realised the importance of the funeral plan which had been put in place for the person. Improvements could be made with the support staff received following the death of a person living at the home. We spoke with the registered manager who was going to liaise with the hospice and put further support in place.

We discussed with the registered manager and staff how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. One member of staff told us they use a variety of techniques to suit the person. One person with sight difficulties was spoken to about their choices; another person was given objects to point at. The registered manager explained they wanted to ensure the information was as accessible as possible. They were currently reviewing all the formats the new provider had to match what was most suitable for the people they supported.

People communicated when they were not happy through their behaviour. Staff knew them well and recognised when they were upset. One relative told us their family member, "Only has to whimper and they [meaning staff] find out what is wrong". Relatives were aware of how to raise a concern informed us they would not hesitate. One relative said, "I would complain to the house. Then try and find someone higher". Another relative said, "I have nothing to complain about". There was a robust complaint system in place to manage formal complaints. There was an electronic system which improved people and relatives receiving a timely response. Relatives confirmed they felt any concerns would be managed quickly by the staff and management.

Good

Is the service well-led?

Our findings

People had a positive relationship with the registered manager. Every time the registered manager walked in the room people smiled and went to engage with them. It was clear people were comfortable in their presence and enjoyed being engaged by them. Relatives and staff spoke highly about the registered manager. One relative said, "I know [name of registered manager] very well. He is always helpful and kind. I can always phone up. Very thoughtful". One member of staff said, "He [meaning the registered manager] is approachable, honest and down to earth".

The registered manager was a qualified learning disability nurse. They wanted to keep their knowledge up to date with current best practice. It also allowed them to develop links with a local college so they could have student nurses on placement. The registered manager explained how valuable this experience was for the students because they had an opportunity to see a different setting. They also encouraged students from the local college completing specialist health and social care qualifications to gain hands on experience. By allowing students they were able to witness the, "Very personal, intimate relationship" staff developed with people they support.

People were supported by a provider and management who had a system to monitor the quality and committed to on-going improvement to people's care and support. Quality assurance systems identified areas for improvement. These were then acted upon. For example, one review by the provider identified people's personal evacuation plans in the event of a fire needed updating. This was so they included guidance for staff about a new piece of equipment to be used. The evacuation plans now contained information about this. Recently, there had been a health and safety review by an external provider. Within the report there were suggestions for improvements to the home. The home's main diary demonstrated when this work on the home had been planned.

The provider was aware the home and staff had been facing a lot of change. There continued to be regular meetings when changes were going to be introduced. This was to ensure there was a drive to provide high quality care whilst respecting the need for people and staff to adapt. It was clear through the provider audits that the care planning and paperwork was still being developed to put the person at the centre of their care. The registered manager showed us some of the new care plan documents they were going to implement which were ways to identify goals and aspirations of people. The scheme around medicine management to reduce the amount of medicine people were reliant upon when using the service was still in place. Staff we spoke with were aware of the medicine initiative.

Staff all agreed it was still unclear what was happening at provider level. One member of staff said, "We try and keep quiet and professional" so it does not impact on the people. Other members of staff told us, "We pull together and support each other", "We are a good team. We work well together" and, "Staff are still anxious". All the staff were clear they did their upmost to prevent any impact on the people. It was clear during the inspection this was the case other than the type of activities people participated in. The registered manager told us they did their best to keep staff up to date with any further news from the provider. They informed us of another meeting which was meant to lead to further clarity.

The provider and management were constantly trying to learn from and improve the service people were receiving. One relative said, "That is [their] home". Another relative said, "I couldn't wish for a better home. [They are] very happy there". When information about new potential concerns in the care industry was learnt about new systems were put in place to proactively prevent risks to people. For example, monitoring people with communication difficulties who are on specific medicines. There were memos sent round to all services so they could implement monitoring systems. Staff had already put them in place for people. The registered manager was clear about this new initiative.

People, relatives and visitors were encouraged to contribute their ideas to help improve the service. Feedback cards were available for anyone who came to the home. One feedback card read, "I have only heard good things about this home and I was not disappointed when I visited. Very knowledgeable and welcoming staff". The provider ran parent and carer surveys as a way of hearing what was going well and what could be improved. They responded to these by reviewing support people were receiving. There were involvement and engagement forums as another way people and their relatives could get involved. Through this they would run listening events and test out new ideas which could be commented upon. The provider included relatives and people on their own Board of Trustees. This was to ensure the people's views and voice were captured at all levels.

The provider and management sought advice and guidance from external agencies to ensure the most current best practice was in place. Recently, they had built a partnership with the National Development Team of Inclusion who were reviewing how the organisation involved everyone. The aim was to ensure as many people and relatives had a voice in driving the provider forwards. They were also going to look at how to make information more accessible for everyone using the provider's services.
People were supported by staff who had a clear line of accountability. The home was overseen by a registered manager who was supported by team leaders and support workers. A performance coach was employed by the provider to work alongside the area manager and provide additional support. The registered manager was positive about most of the support they received from the provider and access to other specialist professionals such as human resources and a quality lead. Staff felt supported on a daily basis through their discussions with the management. There was one occasion the staff did not feel they received guidance from the provider and registered manager. This was when a person was supported through end of life care. Staff felt a better debrief and more emotional support should have been provided to them for their well-being
The registered manager was proud of the close working relationship the management and staff had developed with the community including other health professionals. When there had been some misunderstandings between the local GP surgery they had made an effort to meet with them and resolve it. This had led to a stronger relationship to support the people. There were strong links with the local church and people regularly went to a local pub. This meant the people were involved in their community and their well-being had been considered.

The registered manager and provider were aware of when notifications should be sent in line with current legislation. There had been notifications received in line with statutory requirements to inform the Care Quality Commission (CQC) when people had been hurt or there was a death. There was a system which was in place to monitor all incidents. This would highlight if appropriate action had been taken including sending notifications to external parties such as CQC.