Barchester Healthcare Homes Limited

Castle Park

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

We undertook this unannounced inspection on the 6 and 7 October 2014. The last inspection was completed on 18 November 2013 and no actions were required.

Castle Park can support up to 27 people who have physical and/or learning disabilities; there were 22 people resident at the time of the inspection. It is a single storey building with bedrooms designed for single occupancy, 10 of which have en-suite facilities. There are sufficient bathrooms and communal rooms for people to use. Castle Park is situated on a residential estate and is close to bus routes into Hull city centre.

The service had a registered manager who had been in post since February 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 lived in a safe environment. Staff knew how to protect people from abuse and they ensured that equipment used in the service was checked and maintained. Staff made sure that risk assessments were carried out and took steps to minimise risks without taking away people's right to make decisions.

There were sufficient staff on duty day and night to meet people's needs. Staff, which consisted of qualified nurses, care workers and ancillary workers, received training and support to enable them to carry out their tasks in a skilled and confident way.

When people were assessed as lacking the capacity to make their own decisions, meetings were held with relatives and health and social care professionals to plan care that was in the person's best interests.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in activities provided in the service.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. Staff involved people in decisions about the service.

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?

Good

The service was safe. The people who used the service and the relatives we spoke with had no concerns about the safety of the service. Staff had received training in how to safeguard people from abuse and knew what to do if they had concerns.

When risks to individuals or the environment had been identified, steps had been taken to minimise them to keep people safe.

There were sufficient staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

Is the service effective?

Good

The service was effective. Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people.

Staff gained consent from people prior to providing care. When people were unable to give consent, appropriate steps were taken to ensure care was provided in people's best interests. Any restrictions placed on people's care and movements had been authorised by the local authority.

The meals provided ensured that people received a nutritious and balanced diet. Some people had support from health professionals regarding their nutritional intake.

People were referred to health professionals in a timely way so they could receive prompt and timely treatment when required.

Is the service caring?

Good

The service was caring. We observed staff sit and chat with people. We saw they knew people well, were kind in their approach, patient with them and ensured they had time to respond to questions.

People and the relatives we spoke with told us they were happy with the care they received. Two people had been involved in interviewing potential new staff, which helped them to feel included in decisions made in the service.

The care files provided information about people's life history and their preferences for how care should be carried out. We observed staff promoting privacy and dignity.

Is the service responsive?

Good

The service was responsive. People had assessments, risk assessments and care plans that guided staff in how to support them.

People were able to make choices and decisions about aspects of their lives. This helped them to retain some control and to be as independent as possible.

Summary of findings

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well-led. The registered manager made herself available to people and staff. People who used the service said they could chat to the manager, relatives said they were understanding and knowledgeable and staff said they were approachable.

The service had an open culture where people could raise concerns. There were various means for this such as meetings, questionnaires and the manager having an 'open door' policy.

There was a quality monitoring system that consisted of audits and checks to make sure the care provided to people met their needs and the environment was safe.

Castle Park

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 checked 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 6 and 7 October 2014 and was unannounced.

The inspection was led by an adult social care inspector who was accompanied by a specialist professional advisor. The specialist professional advisor had experience of the care needs of people living with a learning disability or a mental health need.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received information from a health professional who visited the service and we contacted the local commissioning team for information.

Prior to the inspection we looked at the notifications we had received from the provider. These gave us information about how well the provider managed incidents that affected the welfare of people who used the service.

During the inspection we observed how staff interacted with people who used the service. 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 spoke with three people who used the service, two of their relatives, the site manager, the registered manager, one nurse, four care staff, the head of maintenance and a housekeeper. We also spoke with another health professional during the inspection.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service. These included three medication administration records (MARs) in detail, assessments carried out under the Mental Capacity Act 2005, the four Deprivation of Liberty Safeguards that had been authorised by the local authority and the three 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms that were in place.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, the training, supervision and appraisal matrix, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits, maintenance of equipment records, four policies and procedures, the staff handbook and a template of the staff induction process.

Good

Is the service safe?

Our findings

We spoke with three people who used the service and two of their relatives. People told us they felt safe living in the service. Relatives said, "He is in a good place and is really settled" and "The staff are on the ball."

The service had policies and procedures in place to guide staff in safeguarding people from abuse. The registered manager described the local authority safeguarding procedures. She said this consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. The registered manager and two senior nurses had completed training facilitated by the Hull Safeguarding Board in the use of the risk matrix tool.

In discussions with one nurse and three care staff, it was clear they were aware of the safeguarding policies and procedures. The staff confirmed they had completed safeguarding training. They could describe the different types of abuse, what signs to look for and what actions to take should they become aware of abuse or poor practice. Staff said they would take action to protect the person at risk, report concerns to their line manager and make a record of the concern. They said, "We have a flow chart that includes a number to ring" and "There is a poster in the staff room and at the nurses station." Documentation showed us staff completed safeguarding awareness training during the induction period and additional safeguarding training on an annual basis.

The care files included assessments of risk for areas such as moving and handling, falls, nutrition, fragile skin, smoking and behaviours that could be challenging to the person or the staff who supported them. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. The registered manager told us they planned ahead to manage risks. For example, they had just assessed a person who would be admitted to the service in the near future and they had a risk of falls. The registered manager had obtained a sensor mat ready to use in the person's bedroom when they arrived.

We spoke with the head of maintenance and looked at documents relating to the service of equipment used in the home. These records showed us equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual checks and servicing. These environmental checks helped to ensure the safety of people who used the service.

The manager described the procedures in place for foreseeable emergencies. As there were three other services on the Castle Care Village site and another service a short distance away, there were facilities to use in case of evacuation. The care plans identified how people would be evacuated in the case of a fire. There was a 'grab pack' in the corridor for staff to use during any fire emergency. This included equipment and directions for the designated fire marshal. First aid boxes were also prominently sited in the service. A situation had occurred recently when a burst pipe in one of the corridors caused a water leak. This was managed appropriately.

The staff team consisted of qualified nurses, care support workers, housekeepers, catering staff and maintenance personnel. There was a tool used to calculate the dependency levels of people who used the service and this could be used to identify how many staff were required. We observed care was not rushed and staff were available to meet people's needs.

In discussions staff told us they felt there was sufficient staff on duty to meet people's assessed needs. An activity coordinator had recently been appointed and would commence employment when full checks had been carried out. This would enable more in-house activities and more opportunity for people who used the service to access the community. There were additional staff who were designated to provide one to one support for set periods of time for specific people who used the service. This enabled people to participate in activities of their choice. Staff told us, "The majority of the time, I'd say 95%, there is enough staff. Sometimes there is a problem with short notice sickness but we can borrow from other units." A health professional who visited the service told us they had never noticed any staff shortages.

Good

Is the service safe?

We looked at the recruitment files of two care support workers recently employed to work at the service. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). Qualified nurses had their registration checked with the Nursing and Midwifery Council (NMC) to ensure there were no conditions or restrictions on them working as a nurse. These measures ensured that people who used the service were not exposed to staff who were barred from working with vulnerable adults. Interviews were carried out and staff were provided with handbooks and terms and conditions. This helped make sure they were aware of what was expected of them.

The service was part of a large company, with corporate policies and procedures and a human resources (HR) department. The registered manager told us that any disciplinary issues were discussed with HR and guidance followed.

We looked at how medicines were managed within the service and checked three people's medication administration records (MARs) in detail. We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. People told us they received their medicines on time and were not left in pain. We saw that only qualified nurses administered medicines to people who used the service. A nurse spoken with told us they completed competency checks to ensure their skills remained up to date.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us their health needs were met. One person told us they went to their dentist and optician with their family but staff accompanied them on hospital appointments. A relative said, "Staff pick up signs of deterioration and contact his GP; they know him very well."

People who used the service told us there was a good choice of food, ample portions and they were able to make choices about meals. We observed people were able to access the rehabilitation kitchen to make themselves hot or cold drinks. Other people were served drinks at intervals throughout the day.

In discussions, staff were knowledgeable about meeting people's health care needs. They described the signs and symptoms of conditions that would need timely intervention such as loss of weight, chest infections and urinary tract infections. They also described the actions they took to ensure people received treatment from health professionals. They said, "We know the service users and who is at risk especially of chest infections. We monitor them to catch it quickly" and "You get to know people and you know when they are not well."

Two health professionals provided information to us about how the staff met people's health care needs. They told us they received, "Good quality information" from staff that was appropriate and timely. They said, "Seizure documentation is good and they follow plans", "The registered manager keeps me informed if information comes back, like blood results" and "We have good communications, regular meetings and staff keep me informed of any developments or issues. They have always been knowledgeable, kept up to date records and care has been exceptional."

The care files contained guidance for staff in how to meet people's assessed health needs. We saw people had visits from health professionals such as GPs, specialist nurses, dieticians, speech and language therapists, physiotherapists, chiropodists and opticians. Care files for people living with a learning disability had a health action plan and were in a pictorial format to assist communication of the contents. We saw reviews of care plans took place and they were updated when needs changed.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager had made DoLS applications which had been authorised by the local authority. These were documented within people's care plans. Staff were aware of the DoLS and how they impacted on people who used the service and how they were used to keep people safe. The registered manager had notified the CQC of the outcome of the DoLS applications and had included the information in the provider information request we received prior to the inspection. This enabled us to follow up the DoLS and have discussions with the registered manager about them.

Staff had received training in the Mental Capacity Act 2005 and followed the basic principle that people had capacity unless they had been assessed as not having it. In discussions staff were clear about how they gained consent prior to delivering care and treatment. Staff said, "We ask people. The majority of people have capacity for most decisions; we hold up clothes and they can choose and we look for facial expressions", "Some people have capacity that fluctuates", "Some people have capacity and use different communication methods to tell us what they want" and "We use different approaches and different staff if people initially decline care; some service users just prefer different staff."

The registered manager told us there were some people who used the service who did not have the capacity to make their own decisions. When it was assessed that people lacked capacity to make their own decisions, this was recorded and best interest meetings had been held involving health care professionals, relatives where appropriate and senior staff from the home. This ensured any decisions made on the person's behalf were in their best interest.

We saw in care files that some people had assessments of capacity for specific issues. For example, one person had declined to follow health advice regarding the consistency of their meals. A speech and language therapist had assessed the person as requiring a soft diet but the person declined this and requested food of normal consistency. The registered manager had completed an assessment of the person's capacity and recorded their answers to

Good

Is the service effective?

specific questions to test this out. It was deemed the person had capacity to make their own decisions and a meeting was held with the person and their family to discuss how this was to be managed to reduce risk.

People had their nutritional needs assessed prior to admission. The care files contained risk assessments, preferences, likes and dislikes. Meals were prepared in the main kitchen, which was in a building separate from Castle Park, and delivered to the service in special trollies used to keep food hot. However, the service had a small kitchen used by housekeepers and staff to prepare hot drinks and snacks throughout the day. This kitchen had information about people's specific nutritional needs such as the type and consistency of thickeners used in drinks for people with swallowing difficulties.

We observed the meals served to people who used the service. There were two main choices for the lunchtime meal and the member of staff involved knew the choice, portion size and consistency of food to provide to people. They told us they spoke to people to obtain their choice the previous day but always ordered extra in case people changed their minds on the day. Menus were on display which showed there were choices at each meal. We observed people had a choice of where to sit to eat their meals. This usually consisted of the dining room, sitting room, bedrooms or the small rehabilitation kitchen. The rehabilitation kitchen was used to support people with daily tasks such as washing pots, baking and preparing a meal. On the day of the inspection the main dining room was cordoned off. This was to allow for the construction of a summer room to be added onto the dining room. This was due for completion in the next few weeks.

We looked at staff training records and saw that staff had access to a range of training both essential and service specific. Staff confirmed they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed that 93% of staff had participated in a fire drill. Records showed staff participated in additional training to guide them when supporting the physical and mental health care needs of people who used the service. Some of this training was facilitated by health professionals involved in people's care and treatment. There were additional courses for staff development. Members of staff said, "We do a lot of training", "I'm due to have Huntington's and epilepsy training soon" and "Some courses are computerised, some distance learning and some face to face." In discussions, staff confirmed they completed an initial induction where they shadowed more experienced staff and completed workbooks.

Staff confirmed they had supervision meetings and appraisals with their line manager. This assisted staff and management to identify training needs and development opportunities. Staff told us, "I'm involved as a mentor, training and orientating new staff, acting as a role model to show patience and compassion" and "Initially I felt I needed more support. I had a meeting to discuss it and now it's better; I have supervision and appraisal."

Good

Is the service caring?

Our findings

People who used the service and their relatives told us they were happy with the care they received. One person told us they had been fully involved in the care they received. People said, “The staff are alright; they encourage you to be independent” and “The staff are very good at cleaning and tidying my room.” A visitor said, “My relative has two main, one to one carers and they are absolutely superb.” They described a situation when their relative was admitted to hospital and a member of staff went to the hospital and sat up with them all night. They said, “The carer stood up to staff at the hospital and we nominated them for carer of the month”. They said they were very involved in the care their relative received and considered care was shared between themselves and staff at the service.

The care files provided information about people’s life history and their preferences for how care should be carried out. This showed that people and their relatives had been involved in assessments and plans of care. Staff confirmed they read care plans and had a key worker role with specific people. This helped them to build up relationships, get to know people and their needs, and liaise with relatives. Some people who used the service had communication needs. These had been described in care plans so staff were aware of the best way to communicate with people. We saw some people communicated with the use of pictures and another person had electronic equipment to communicate. Some people had signed their care plans to show they agreed to the contents. Reviews were held where people, their relatives and professionals attended so that care could be evaluated and discussed.

We observed good interaction between staff and the people they cared for during the two days of the inspection. We saw staff speak with people in a friendly and patient way; they gave explanations of tasks and provided time for people to respond. We observed staff support someone to adjust their clothing in a discreet manner to protect their dignity and we saw staff had friendly banter with people. The specialist professional advisor reported they had observed staff showed a lot of care and dedication to people and treated them with dignity and respect. They observed staff sat and chatted to people and also observed an activity in the sitting room which involved singing and clapping, which people enjoyed.

We observed staff promoted people’s privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. They offered clothes protectors at lunchtime to people and supported them to eat their meals in a sensitive way. A relative told us, “We have seen them close curtains and doors and keep him covered.” They also told us they were able to visit at any time and staff kept them informed about any problems. In discussions, staff had a good understanding of how to promote privacy, dignity, choice and independence. They said, “We close doors and curtains and gain consent for tasks. We don’t just barge in. We use products they want and we are always assessing to see what they can and can’t do for themselves”, “They have choice in everything from clothes to lunch to care and activities” and “When we assist people to the toilet we ask them if they want us to stay or leave and make sure the buzzer is there.” The registered manager showed us a policy and procedure on privacy and dignity and was very clear about staff expectations in this area. They told us people had a choice of male or female care workers to support them and this was discussed at the assessment stage prior to admission.

All bedrooms were for single occupancy and some had en-suite facilities. The registered manager told us one of the bedrooms was, in the past, used for shared occupancy but had since been reassigned for single use. They told us people who used the service preferred their own bedroom and this afforded them their privacy.

The registered manager told us that two people who used the service had been involved in the interview process for an activities coordinator. They were supported to plan the questions they wanted to ask the interviewees and one had used a specific communication tool to ask their questions. One of these people confirmed they had interviewed the potential employee. The inclusion on the interview panel helped them to feel they were involved in decisions about care and support.

We spoke with staff about how they supported people at the end of their lives. Staff gave an example of how they had supported a person by making sure there was always someone with them, by making sure they were pain-free, by supporting their family and keeping them informed. Staff also described the practical tasks they were involved in to ensure the person received all the care they required,

Good

Is the service caring?

such as mouth care, pressure relief and making them comfortable. The care file for one person who had recently received end of life care showed they had received individualised care which included care that met their religious needs.

The registered manager described the links they had made with local teams providing support with end of life care. They explained how input from the McMillan nurses had provided them with ideas to improve the quality of life for a person and their relatives. There were plans to develop an end of life pathway and to hold a clinic on site with health professionals such as the McMillan nurses and GPs.

We saw there was information about a specific advocacy service that was used when people required this support. The registered manager confirmed there were two people who used the service who currently had support from the advocacy service.

Good

Is the service responsive?

Our findings

People spoken with told us they felt able to complain and that they would be addressed. One person told us there used to be a room designated for arts and crafts but this had been turned into a sensory room so more people could use it. They said this had disappointed them, as they used to use it for painting. However, they told us that after discussion, staff had moved them to a larger bedroom and organised a table for them to continue with their art. One person said, "I made a complaint about the food being overcooked and tasteless. I told the manager about it and within a week the food was better and tasted nice."

People told us they could participate in visits to community facilities. One person told us they went to a nearby golf course whenever they had the opportunity. People had participated in a range of activities and outings such as walks, swimming, visits to the shops, pubs and cafes, a holiday to the coast, use of the sensory room, baking and preparing food, watching DVDs, crafts and music sessions. The registered manager told us that some people had requested to complete an assisted sky dive and fund raising was underway for this. There were colourful notice boards that provided information about activities. Some people went to day centres and one person was completing their education at college. Some people preferred to stay in their bedrooms and watch television or listen to music and this was respected.

A visitor told us staff were responsive to their relative's needs. They said staff had taken information about their health care needs to hospital during admission and described the correct moving, handling and positioning techniques to hospital staff. They also told us staff were very aware of their relative's specific nutritional needs and made sure these did not affect their leisure activities. They also told us they were fully involved in reviews and changes to care plans when their relative's needs changed.

We saw in care files that people who used the service had their needs assessed and plans of care were developed to guide staff in how to meet them and keep them safe. The care plans were individualised and updated when needs changed and annual reviews were held to discuss the progress of care and support. We saw the care files contained a lot of information in different sections and for new staff information would be difficult to locate quickly.

The registered manager told us she was looking at how to streamline some of the information and to produce a sheet at the front of the file that contained basic, important information.

In care files we saw people had individual risk assessments and management plans to minimise risk so staff could respond to their needs. For example one person chose to smoke cigarettes but did not want to use the designated area, as this was too far for them to walk unaided and they preferred to be independent. Staff supported the person to smoke in an outside area closer to their bedroom. We saw that one risk management plan referred to decisions the person had made which was contrary to advice from health professionals. As the person was able to make their own decisions staff supported the person in their decision making and monitored them closely. Staff had liaised with health professionals to ensure they were fully aware of the person's decisions and minutes of meetings and visits from professionals were recorded.

In discussions staff told us they had handovers at each shift change. They used this time to discuss the people who used the service and any concerns that had been raised. These meetings helped staff to receive up to date information about people. There were information sheets in care files for use when people were admitted to hospital to provide staff with important details about health needs such as mobility and personal care. We saw there was an inconsistency in the amount of information in these 'patient passports'. Some were completed fully and would provide hospital staff with good information about individual needs whilst others had only basic information. The registered manager told us they would ensure these were completed with appropriate information.

The registered manager described a new pilot system that was being introduced which involved a face to face televised link with a specific hospital. This would enable staff to see and speak directly with health professionals about people's health care needs and symptoms, 24 hours a day. The registered manager told us she hoped this would enable a quick response to people's health care needs when required.

During a tour of the environment we saw people were able to have small animals as pets such as birds and fish and were able to personalise their bedrooms. Staff told us this helped people to feel Castle Park was their home. We observed people walking freely about the service and

Good

Is the service responsive?

spending time either in their bedroom or the sitting room. There was no access to the dining room but this was due to building work and in response to the need for more communal space. People understood this and we saw the building work was almost finished. The work had been completed quickly to avoid lengthy disruption for people.

The environment had been adjusted to support people with different levels of needs. There was specialist moving and handling equipment for people with mobility issues, wide corridors for people who used wheelchairs, hand rails to assist independent mobility, signage and symbols, safety equipment such as profile beds and sensor mats and a range of pressure relieving equipment to meet specific needs. There was a rehabilitation kitchen and the registered manager told us they had recently requested a ceiling track hoist for one person who used the service. This had been agreed by the registered provider and they were sourcing a company to fit the hoist. Relatives also told us the entrance caused a problem when manoeuvring wheelchairs through it. The registered manager said this had been mentioned in meetings with relatives and a new door entry system was to be fitted once work on the dining room had been completed. This showed us the registered provider was responsive to people's needs.

There was a complaints policy and procedure in type and an easy read format that included pictures and symbols. This described what people could do if they were unhappy with any aspect of their care. We looked at the complaints file maintained by the registered manager. We saw that niggles and complaints were documented and showed that action was taken to address them. For example, the designated area for smoking was too far for one person to walk to safely and independently so this was resolved with the provision of a bench and a bin outside their bedroom door, which led onto a patio area. Staff said, "We use complaints to improve things."

Good

Is the service well-led?

Our findings

At the time of the inspection the service had a manager who had been registered with the Care Quality Commission since February 2014. There was an overall site manager who was based in Castle Park to support and advise the registered manager as required.

We spoke with the registered manager about the culture of the organisation and how they ensured people who used the service and staff were able to discuss issues openly. The registered provider had a mission statement which referred to 'putting quality first' in all areas such as the care provided to people, staff who support people and the environment in which people live. The mission statement also highlighted important values such as respect and appreciating the individuality of people. The mission statement was included in staff induction and in the staff handbook. In discussions with staff they reflected some of these values. They said, "People are individuals and we treat people in a person-centred way" and "They invest in staff; there are incentives to keep up training, chocolate and wine for the carer of the month and vouchers for long service." Staff told us they, "Explained choices", "Care planned important information", "Assisted people to be independent" and "Used complaints to improve things."

Minutes of staff meetings showed staff were reminded about attitudes and behaviours and to ensure people who used the service were checked each morning and greeted appropriately. Staff told us the meetings were a way of raising issues and they were able to make suggestions.

Staff spoken with said they were always able to speak to the registered manager or overall site manager. They described the registered manager as approachable and available. Relatives said, "The manager is available when we visit" and "There is settled staff at the moment and a good manager who is understanding and knowledgeable. They have moved managers around in the past and that could be a problem."

People we spoke with knew the registered manager's name and said they had the opportunity to speak with her each day. One person said, "The manager comes around a lot to chat and have a laugh with us." During the inspection we observed the registered manager's interactions with people who used the service. She knew people's names and their relatives, she stopped and spoke with people and asked about their plans for the day, she spoke with staff to pass on information and she checked the environment. We saw the registered manager had a calm and unhurried approach.

Meetings were held with people who used the service and minutes of them, and actions taken, were displayed on the notice board. There was a 'You said, we did' information sheet pinned to the board. This mentioned that people who used the service had raised issues with the quality of the food and with the amount of activities on offer. The notice described the action the registered manager had taken in response to these issues. These included meetings between individual people who used the service and the chef to listen to people's suggestions, a meeting with senior managers to discuss improvements in the menus, the appointment of an activities coordinator and arranged outings to use community facilities.

The service had an 'Expert by Experience' project. This involved two people who used the service discussing issues with their peers and feeding this information to the registered manager so they could make changes.

There was a quality monitoring system that consisted of an annual care and quality audit programme. This included monthly audit tasks, meetings, questionnaires and analysis of information inputted into an electronic clinical governance programme. There was also a three monthly audit tool completed by the registered manager. Action plans were produced when shortfalls were highlighted and a review system built into the programme to check that actions had been completed. We looked at some of the quality audits completed by staff and the registered manager. These included a check on documentation, infection prevention and control, medication, safeguarding, accidents, weight monitoring, infections such as chest and urinary tract infections, wound care and the environment. The audits showed us action was taken when issues were identified; staff signed when actions had been completed.

The service had a designated lead for health and safety. Meetings were held to discuss health and safety issues with the head of maintenance, the registered manager, the head of housekeeping and the designated health and safety lead. Action plans were put in place when issues required addressing.

The registered manager had a good understanding of their role and responsibilities in managing the service. They told

Good

Is the service well-led?

us of the importance of communication within the service and described how this had been improved by having '10 at 10' meetings. These were in addition to staff handovers and were quick 10 minute discussions with staff at about 10am to pass on relevant information to keep staff informed.

The registered manager informed the Care Quality Commission and other agencies when incidents occurred that affected the safety and welfare of people who used the service. This enabled us to contact the service to be assured these incidents were managed appropriately. The registered manager told us they had used National Institute of Clinical Excellence (NICE) guidelines when they planned their winter flu policy. This included ensuring staff as well as people who used the service were offered flu vaccination. They had also used NICE guidelines when looking at the staffing ratio. They said this had led to the employment of an apprentice.

The registered manager told us they attended a local authority and health led 'learning disability forum'. This helped them to keep up to date with current practice and enabled them to make contacts with other registered managers. They said they had received guidance from contacts at the meeting regarding decoration and the use of sensory equipment.

The service had 'Investors in People' status. This was an accreditation scheme that focussed on the registered provider's commitment to good business and people management.