East And West Healthcare Limited

The Mews

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 06 and 07 March 2018. This was the first comprehensive rated inspection of the service since it changed ownership in 2017. A previous inspection in April 2016 under the previous ownership identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) in that some equipment and parts of the premises were not adequately maintained or suitable for their required purpose, and staff did not always receive mandatory training and supervision in line with the provider's policies and procedures. At this inspection we found improvements had been made and the service is no longer in breach of the regulations.

The Mews is a service which provides accommodation, personal care and nursing care and provides care and support to young people with disabilities. It comprises of three units situated over four floors. It is built on the side of a hill and terraced, which means all floors have direct access to outside areas. Nursing care is provided by qualified nurses who are supported by care assistants. The service has 50 single bedrooms and at the time of our inspection there were 48 people living in the service.

There was a culture of openness and transparency at the service. Although the service supported people with a variety of extremely complex needs the environment was more homely than clinical. Imaginative furniture arrangements minimised the risk of accidental injury, and the non-clinical environment did not detract from the high quality of care and support provided. Care was provided in a calm and relaxed environment. There was a real sense of community throughout the service; people who used the service were stimulated with a wide range of activities, their needs were addressed and they appeared content. They told us that they got on well with staff and were well supported. They had made friends and enjoyed living at the Mews. The staff we spoke with enjoyed working at The Mews and told us they felt a sense of fulfilment. Most of the people working there had done so for a long time, with very little staff turnover.

People felt they had a stake in the service and a say in how the service was managed. Staff were extremely positive about the people they supported and management and leadership inspired them to deliver a high quality service.

People were safe. There were few allegations of abuse, and those that were raised were taken seriously and fully investigated. Accidents and incidents were recorded and analysed for trends, with a view to preventing repeat occurrences.

The service took a proactive approach to risk and risk taking. Staff worked collaboratively and with mutual respect for other professionals and agencies so that people's social, emotional and physical needs were met. This helped them to lead an exceptionally high quality of life. People's care and support was planned proactively with them and whilst areas of potential risk had been continually assessed lifestyle choices were respected. Whilst recognising their rights to live their lives the way they chose, staff worked closely with people to consider ways of reducing the risk their choices might incur.

Privacy and dignity were respected, and people were supported by very kind, caring and compassionate staff who routinely went above and beyond what was expected of them to provide people with excellent, high quality care.

People told us that they were well cared for in a welcoming and inclusive environment. Nothing seemed to be too much trouble for the staff.

We saw that there were enough staff to meet people's needs across all three units of The Mews. Recruitment systems in place ensured staff shared a similar value base and reflected the local population. We saw staff had access to good face to face training and a programme of ongoing learning and development.

People told us that they enjoyed the food on offer and we saw mealtimes were a merry and social occasion. Attention was paid to people's dietary needs, and the menu reflected people's tastes and preferences. People who used the service told us that they had had a hand in planning the menus at The Mews.

There was good communication between staff which allowed continuity of care, and the service had developed impressive relationships with external health and social care organisations.

The service was extremely person centred, and people had choice in all aspects of their care. People had a real say not only in how their own care was to be delivered but also in how the service was run. Good care records reflected delivery of person centred care in all interventions, and people were encouraged to maintain their independence and autonomy. There was a clear understanding that people were not defined by their disability, and were encouraged to maintain their own lifestyle. Disability was secondary to the person.

The service demonstrated an innovative approach to providing stimulation and activity to all the people who used the service. Three full time activity co-ordinators ensured that people had access to activities either on a one to one basis or in groups, and people were supported to maintain their hobbies and interests. Nothing was considered to be off limits.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This person was respected by the staff and people who used the service. He was supported by the new owners, who had shown a willingness to invest in the service. The registered manager was equally supported by a strong staff team who shared his values and worked to promote the needs of the people who lived at The Mews. We saw that the registered manager consistently sought to make the lives of the people who used the service better; auditing systems identified areas for improvement, and he sought criticism as a way of learning how to enhance the quality of the service.

The registered manager, and unit managers were always visible and available to listen to people and their relatives to offer them choice and make them feel that they mattered.

People were at the heart of everything the provider did and were consulted and involved in everything.

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.

Clear procedures and practices were in place to protect people from potential abuse without limiting their independence

Detailed and robust risk assessments were developed alongside the people who used the service to identify any risks to people.

Staffing levels ensured a high standard of support was provided.

Is the service effective?

Good

The service was effective

Staff received a comprehensive induction to the organisation and ongoing learning and development opportunities were tailored to ensure people experienced effective care and support.

People enjoyed the food and drink provided, and their dietary requirements were met. Menus reflected people's food preferences.

Staff understood people's physical, mental and medical needs, and liaised appropriately with relevant health care professionals.

Is the service caring?

Outstanding

The service was outstandingly caring.

People were supported by staff who were committed to providing high quality care and had an excellent understanding of their needs.

People and staff knew each other well. These relationships were based on trust and people were truly valued.

The registered manager and staff consulted and worked closely with people and their families to ensure they were always actively involved in all decisions about the care being provided.

Is the service responsive?

Outstanding ☆

The service was outstandingly responsive.

People were not defined by their disability. The registered manager and staff provided outstanding support to enable people to achieve an exceptional quality of life.

People's support plans had been planned, developed and agreed proactively in partnership with them.

People were offered meaningful and person centred choices of activities both in the home and the wider community.

Is the service well-led?

Good ●

The service was well-led.

People felt they mattered and were encouraged to live as independently as possible.

People, their relatives, staff and appropriate professionals expressed high levels of confidence in the management and leadership at the service.

Extensive quality assurance systems were in place and fully utilised. There was a strong emphasis on the service to continually strive to improve

The Mews

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 of The Mews took place on 6 and 7 March 2018 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the information we held on the service. This included notifications we had received. A notification is information about important events such as accidents or incidents, which the provider is required to send to us by law. Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about The Mews and were satisfied with the level of care provided.

The provider had completed and returned their 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 contacted the local authority professionals who were responsible for organising and commissioning the service on behalf of individuals and their families. In addition we contacted the Infection Prevention and Control Team and the Rochdale Healthwatch Officer.

As some of the people living at The Mews were not able to tell us about their experiences, we undertook a Short Observation Framework for Inspection (SOFI) observation. A SOFI is a specific way of observing care to help us understand the experience of people who are not able to talk with us.

During the inspection we spoke with twelve people who used the service, four visitors, two visiting professionals, the registered manager, two unit managers, five care staff and two nursing staff, a member of the activity team, the cook and a housekeeper. We looked around all areas of the home, looked at food provision, six people's care records, five staff recruitment files, induction, training and staff supervision

records, records relating to medicine administration and records about the management of the home.

Good

Is the service safe?

Our findings

Reflecting on their care and support at the Mews, one person who used the service told us, "It's fabulous. This place has saved my life… I know I am well looked after; if they didn't keep an eye on me I'd be dead now! I couldn't cope on my own. I'm happy, and I've no problems". Another person who used the service said, "They [the staff] definitely keep us safe. They have the skills and the knowledge. I have nothing bad to say about this place, the food is excellent, the staff are very good, I sleep very well. I am very well looked after". A visiting relative told us, "[My relative] is safe. Before coming here, I used to have sleepless nights worrying, but now I know he is in safe hands", and another echoed this: "[My relative] is OK here; very well looked after. I know she is safe".

Policies and procedures, including safeguarding and whistleblowing were designed to minimise the risk of harm. Whistleblowing provides a commitment by the service to encourage staff to report genuine concerns around poor practice without recrimination. Records showed that all staff had received training in these areas, and when we spoke with them they demonstrated an understanding of what might constitute harm and the procedures for responding to and reporting allegations of abuse. We saw evidence that when safeguarding alerts had been raised appropriate protective measures were put into place and allegations were fully investigated. Staff were watchful for any potential concern. One visiting relative remarked, "Staff are on to [any conflict], they know how to keep people apart and when trouble might be brewing, so they keep a lid on it".

A number of the people we spoke with told us that they would go into the local community. However, the service recognised people's vulnerabilities, for example, the risk of exploitation for people with acquired brain injury, or harm from alcohol for people with a history of alcohol misuse. Staff worked closely with people to help them explore the risks of their lifestyle choice and consider appropriate strategies to minimise harm without impeding their independence.

We saw the service had taken a proactive approach to managing risks. These included analysis, identification and review of over 100 environmental risks and hazards. Each risk assessment identified the hazard, who might be affected, any control measures in place and any further measures required.

A personal emergency evacuation plan (PEEP) had been developed for each person who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency. A copy was kept in each file and reviewed on a monthly basis. When we reviewed the PEEPs we saw a large number of the people who used the service would require assistance to evacuate the premises, for instance, on one unit 17 people required hoisting. Regular fire drills had helped staff to rehearse actions required in case of a fire, and reduced the time to evacuate people to a place of safety.

The service employed a full time maintenance officer who would undertake any small maintenance jobs in the home, and complete weekly checks on systems such as nurse call and alarms, passenger lift and evacuation chairs, and water temperature. Further records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included

checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The service also had a business continuity plan in place which contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

Clear and robust risk assessments had been completed with people who used the service to enable staff to safely promote and maintain people's independence. Individual assessments were specific to the person and took their views and wishes into account as well as their physical, emotional, and cognitive ability, and considered any environmental factors. One support plan we looked at for a person who lacked capacity identified their unsteady mobility as a risk, and instructed staff on how to support the person, maintaining their dignity and independence. Assessments recognised the risk particular behaviours might pose to other people who used the service, and provided clear and detailed instructions to help 'distract' or help the person to engage in activities. When we spoke to staff they were able to tell us how they used these strategies to ensure a safe environment for all the people in the unit. This showed that areas of potential risk had been assessed, identified and appropriate action identified to help reduce or eliminate the risks to the person and other people.

We saw that people were enabled to take ownership of their own risks. For example, we noted that one person had a large number of falls, accounting for most of the accidents and incidents on their unit. The risk assessment identified that the likelihood of accidents and the severity of injury would both score highly, but the recorded discussions with the person reflected their recognition of risk and capacity to make their own decisions. The care plan noted the person's disinclination to have any aids or adaptations which might help reduce the likelihood of falls but recognised that these would reduce their self-autonomy. We saw some agreed measures were in place to prevent injury; the care plan indicated why protective measures and advice from the Falls Team had been refused by the person and instructed discreet observation, and continued recording of any incidents. This had not reduced the number of falls, but had minimised the level of harm. This showed that the service proactively engaged with people to assess and mitigate risk in a way which maximised people's autonomy and independence.

Recruitment procedures in place were robust and safe. We looked at five staff personnel files which showed they had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. Volunteers were also DBS checked. Each person's file included an up to date photograph of the person, and where nurses were employed a copy of their personal Identification number (PIN) was kept on file. In order to work as a nurse, a person must be registered with the Nursing and Midwifery Council (NMC) and have a unique PIN. The registered manager told us that he reviewed the registration details of all nurses. During our inspection we saw there were sufficient staff on duty to meet the needs of the people who used the service. There was a minimum of four care workers and a nurse on Meadowview and Fernview units during the day with two care workers and a nurse at night, and three care workers and a nurse on Pennineview. When we reviewed the previous two months rotas we saw that this was generally the case. The service had a small bank of staff who were familiar with the service and could be called to cover any gaps on the rota. Any further gaps were covered by agency staff.

Staff were recruited to work on a specific unit. This meant that they got to know not only the people who used the service and how they liked their needs to be met but also allowed them to develop their knowledge, understanding and expertise around the specific conditions and illnesses that affected the lives of the people they supported. Staff turnover was low, and most of the staff had worked at The Mews for a long time, some for over ten or fifteen years. A visiting relative commented, "Continuity of care is important,

and there is very minimal turnover of staff here. People see the same faces each day which is very reassuring". Staff agreed, one nurse told us, "I like it here. It's a real community. We have a settled team; staff stay a long time. We know each other and how each of us works, so it's good for sharing and allocating tasks".

We saw from care plans that people were asked if they would like to take responsibility for their own medicines, but at the time of our inspection nobody wanted to do this. This was recorded in the care plans. All medicines were administered by a nurse on each unit, who had been trained to do so, and had their competency checked to ensure that they continued to administer medicines safely.

Medicines were stored in locked rooms on each unit and only staff who needed to had access to the keys. These rooms were well equipped with padlocks to secure medicine trolleys when not in use; a lockable strongbox attached to the wall to store controlled drugs, a dedicated medicines fridge, a 'sharps box' to store any used or contaminated medical equipment such as needles, and a pestle and mortar. There was a signature list of all staff who gave medicines for management to help audit any errors.

A number of people living at The Mews had a percutaneous endoscopic gastrostomy (PEG). This is a medical procedure in which a tube is passed into the person's stomach to provide a means of feeding when the person cannot ingest food orally. The pestle and mortar was used to grind any medicines for people who had a PEG and could be added to their food supplement. Where this was the case we saw written authorisation to do so signed by the persons' doctor.

The temperature of the medicines rooms and fridges were checked daily to ensure medicines were stored to manufacturers' guidelines. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

We looked at eleven medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. There was a photograph on each MAR to help staff identify the correct person.

Controlled drugs (CDs) are medicines named under misuse of drugs legislation. The Misuse of Drugs Regulations 2001 and 2006 restricts how such medicines are stored and recorded. The home used some of these prescribed medicines and we saw they were stored in a further locked cabinet, and the controlled drug register was countersigned when administered, as required. We checked the balance of controlled drugs for three people and found them to be correct. Given the complex physical and health needs of the people who used the service we were impressed at how few people required strong medicines, but the registered manager informed us that the service tried to respond to people's health needs by using environmental factors rather than resorting to medicines which would have the effect of sedating the person and in certain circumstances impact negatively on their quality of life.

By working closely with associated health professionals and the people they supported the staff continuously looked for new and innovative ways to promote independence. By providing adequate space in a stimulating and responsive environment the service did not need to resort to medicine to control people's behaviour or minimise choreic movement (an abnormal involuntary movement). This meant the service sought creative ways to maximise autonomy of the people who lived at The Mews.

Some people were given medicines covertly, which meant that they were given to the person in a disguised form such as sprinkled on food. Where this was the case there was evidence that the person's wishes had been taken into consideration and that best interest procedures had been followed. A covering note from

the person's doctor or consultant was attached to their file with written authorisation to give medicine in this way.

Any medicines that had a used by date had been signed and dated by the care worker who had first used it to ensure staff were aware if it was going out of date, and there was a safe system for disposal. The service used a monitored dosage system (MDS) for tablets, with medicines provided in blister packs by a supplying pharmacy. MDS is used to help keep track of what medicines are administered. This system can help to reduce the risk of medicine errors and help to make sure that people receive the correct medicine as prescribed. Many of the people who used the service had swallowing difficulties meaning that they were unable to take medicines in tablet form and required liquid medicines. Where this was the case, bottles were opened and marked on the day they were opened, and carefully dispensed using measuring cups to ensure the right amount was administered.

Systems in place protected people and staff from infection and cross infection. All staff had attended infection prevention and control training. Staff we spoke to clearly understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Hazardous items such as cleaning materials were stored safely when not in use.

We saw that when accidents and incidents occurred these were recorded, and reviewed to ensure people remained safe. They identified where changes were required to prevent future reoccurrence. A monthly audit on each unit identified trends, and underlying issues were identified with evidence that action was taken to minimise any risk.

Good

Is the service effective?

Our findings

The service worked closely with other agencies to ensure consistent good practice in the care of people with physical disabilities. For example, it had developed close working relationships with the local neurological rehabilitation unit, including establishing a monthly clinic on site to ensure medical and physical health care needs were met using the most up to date standards. Staff actively participated in local forums for care providers and attended other local events and seminars such as provided by the Infection Control Team from the local authority, or health commissioners.

The people who lived at The Mews were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this good practice.

The registered manager told us the service sought to recruit from the local population to build a staff team which reflected its diversity. Recruitment of staff was based on values, and looked to take on staff with a value base similar to the values of the service. People who used the service were encouraged to participate in the recruitment process, which meant that they could have an influence on the outcome and support selection of staff whom they felt would be most suitable to work with them and their peers.

We asked people who used the service and their relatives about the knowledge and skills of the staff team. People who used the service spoke highly of the staff and a visiting relative told us, "They've definitely got the skills, they understand [my relative's] condition and how he likes his needs to be met. So knowledgeable!"

The service supported people with a variety of diverse conditions. The staff told us that they received sufficient training and support to understand how best to work with people; one told us, "We get training in specific subjects, so we understand the diagnoses of [the people we support]. Training is really goods here." A unit manager remarked, "The staff have the skills, and all have their own skill set, so I know who to allocate tasks to. Some lack confidence in their abilities, but will always ask if they are not sure."

A visiting relative told us how all the staff were really knowledgeable about their relatives' condition but one in particular was the "Go to person; they really seem to understand how [the condition] affects [my relative]".

When we last inspected The Mews in April 2016 we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as training of staff was not up to date. Since then the service has undergone a change of ownership and at this inspection we found that a more robust system of training had been introduced. When they first began working at The Mews, all staff completed a comprehensive mandatory learning and development induction programme. For the first four weeks of employment the new starter would be observed completing personal care tasks, supporting people who may present behaviours that challenge service providers, and facilitating social activities. Their communication skills, holistic competency and ability to work in a team were also assessed.

Staff were subject to a six month probationary period and were required to complete the Care Certificate. This is a set of standards that social care and health workers follow in their day to day working. It is the minimum standard that should be covered as part of induction training of new care workers.

Following their induction all staff received ongoing training which was mostly delivered in a training room on the site. This meant that training was bespoke and could be related directly to the needs of the people who used the service, delivered around individual needs. We saw that a training course had been arranged around supporting people living with dementia, and were told by the registered manager that, although the service supported younger people, one person who used the service had a recent diagnosis of dementia, so it was important for all the staff to understand how to work with people living with dementia.

Staff were encouraged to develop specialist skills and knowledge, and would attend ongoing training or enrol on certificated courses. A number of staff had completed Institute of Leadership and Management (ILM) level 5 training in leadership and management, and one nurse we spoke with informed us that they had recently attended a seminar at Manchester University on wound care. A person who used the service told us "This is definitely the best place to be. The staff are very, very good. When you ask a question, there is always someone to ask and they get you the answer. If they don't know it they'll find out. I grazed my elbow, look how they've dressed it: It's all been done properly". All staff were invited to attend in house training which was delivered at a level appropriate to staff understanding. When we spoke with staff they told us that they received the training necessary to do their jobs effectively. One care assistant told us "Our training is up to date. We have a lot of mandatory courses and these are checked each year. Training is good."

All staff had a yearly appraisal which gave them the opportunity to reflect on their work and set targets for the following year. They received a formal supervision session every three months, with additional sessions more frequently if required for 'non-practical and ad hoc concerns' to address any issues around conduct and behaviour. We looked at five records and saw supervision meetings provided staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. There was evidence to show staff used the opportunity supervision provided to reflect productively on improvements to meet need, for example in one supervision record we reviewed there was discussion concerning religious praying times. This increased understanding and respect for religious values and beliefs and allowed for accommodation of religious practice in the service.

People told us they enjoyed the food on offer, that it was plentiful and that they were supplied with hot and cold drinks throughout the day. People who used the service were consulted in planning menus which reflected their preferences. Choices included rice dishes, curries, and other spicy food such as burritos.

Food was freshly prepared on the premises in the main kitchen, and served in dining rooms from smaller kitchens on each unit. Breakfast, either cereal and toast or cooked breakfast was available throughout the morning For both lunch and evening meal there was choice of two main meals and dessert; if people did not want either they could ask for an alternative. One person who used the service told us they often chose something other than what was on the menu. This showed that personal tastes and preferences were taken into account and the service was able to respond to and accommodate peoples' wishes.

Attention was paid to people's nutrition and hydration needs. People were weighed regularly and where appropriate a food and drink chart was used to monitor the amount given and the amount consumed. Records also noted any supplements taken, and when food had been refused, to ensure that people did not go too long without eating or drinking. We saw in the kitchen on Pennineview a list showing how people like drinks (cold preferences, tea and coffee; colour and sweetness) including any thickeners or supplements which may need to be added.

Care plans contained details of any special dietary needs, including detailed advice provided by health professionals. Case notes, shared with kitchen staff and care assistants, contained detailed information on nutritional needs, and meals were prepared in accordance with instruction from speech and language therapists and dieticians, such as fortified diets, or pureed meals. A visiting relative told us, "The food is prepared well. Staff know a lot about dietary needs, and make sure my relative has food prepared the way it should be. We are often here at mealtimes, and the food looks and tastes good."

Throughout our inspection we saw staff communicated well with each other. Prior to each shift staff finishing their work would pass on information to the oncoming teams on each unit. This allowed continuity of care and alerted staff to any concerns or issues to be addressed. Duties were allocated so each member of staff knew what they needed to do. We saw staff received direction during their daily shift from unit managers, and cooperated with one another to ensure that people's needs did not go unmet. At lunchtime, we saw the unit manager on one unit checking that all the people who used the service were being supported and that nobody had been missed.

A visiting general practitioner told us "If they phone me I know it is genuine. They monitor everyone appropriately, and all are healthy." They told us that they were impressed with the quality of health care provision in the service and how people were supported. The registered manager told us that the local GP surgeries would send junior doctors and medical students 'on placement' to observe good practice in care, and the doctor we spoke with confirmed this. The service had developed a good reputation with health professionals and other outside agencies who felt people were extremely well cared for and supported in a person centred fashion. For example a visiting professional who was acting as a court appointed deputy for a person who used the service (P) was moved to write, "I am really pleased to see such an improvement in [P] since moving to The Mews. [P] seems much calmer and more settled, the contents of the conversation much nicer and less inappropriate. Visually [P] looks much better and really well. Generally [P] seems happier and [their] room feels homely and much less clinical. Brilliant to see such improvement and progress".

All the people who lived at The Mews had complex and difficult health needs. Primary diagnoses such as Huntington's disease, Cerebral Palsy and acquired brain injury were complicated by further health concerns such as diabetes and epilepsy. Health needs were carefully monitored, for example, we saw a record showing that a person with unstable diabetes and high fluctuation in blood sugar levels was closely monitored to ensure this was kept in check, minimising the risk of hypo- or hyperglycaemic episodes.

Nursing staff had developed an exemplary clinical knowledge of the associated conditions of the people they supported and looked to maintain their understanding through on-going training and review of current practice in the field of disability. The service had developed excellent links with health and social care agencies, including arrangements for a consultant to visit and conduct a clinic at the service every month. This had allowed staff to improve and keep their learning up to date as well as reducing the need to attend hospital appointments. Care notes included records of consultant and health and social care visits completed by visiting professionals, including dieticians, speech and language therapists, social workers, mental health workers, opticians and dentists. This meant people's needs were consistently monitored and reviewed and met in line with the latest best practice principles.

Whilst meeting people's health needs we saw that care remained person centred and the individual's wishes were pivotal to any intervention. The staff recognised that personal safety was paramount, but the culture of the service reflected the view that measures to make people safe should not hinder their quality of life, and staff would always strive to support people to find a less restrictive option. For example, a person with severe epilepsy could choose if and when to wear a helmet, to help prevent head injury. This helped the

person to maintain their dignity and self-esteem.

The environment was spacious and adapted to meet the needs of people who lived at The Mews. Bedrooms were large enough to accommodate specialist equipment such as hoists and wheelchairs. Corridors were wide and the furniture in communal areas had been arranged to allow people to manoeuvre wheelchairs or walking aids in lounges and throughout the building to minimise the risk of bumps and scrapes. Pennineview, where people with Huntington's disease were supported, had been redesigned to allow freedom of movement and expression, taking into account choreic movement. Areas on each unit were set aside for people to use for their preferred activities or to spend private time with each other or their visitors. The environment was homely rather than clinical. This reflected the understanding that people lived at The Mews, but did not detract from the need to maintain safety. All bedrooms were different and decorated in accordance with people's tastes and wishes, reflecting their personality, but close attention was paid to safety, all had call alarms situated within reach of the bed, and when we toured the building we saw bedrooms were adapted to minimise risk of injury after consultation and discussion with the person. For example where one person was prone to convulsions due to their condition, extra padding and support was placed around the bed to minimise the risk of accidental injury.

All the care records we reviewed included a form to say that the person consented to care and treatment. Where they were unable to sign, their verbal consent was witnessed by a third party. Consent was reviewed regularly, and consent forms updated. Records also included a mental capacity assessment form, but these were only completed if there was a reason to consider whether the person lacked capacity. People told us that their consent was always sought by staff and that they were involved in any decisions made about them. Although the service understood that people could make unwise decisions the staff had developed skilful ways of seeking consent. For example, we saw that one person who used the service would often refuse personal care. We asked the registered manager at what stage would they insist that the person address this need. They told us that there are a number of ways of asking 'do you want a shower?' He told us "If we say, for instance, 'I've run the shower for you' they are more likely to take it". During our inspection we overheard staff asking permission to intervene in a way that did not restrict their choices but offered the best outcome for the person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. At the time of our inspection, twelve people supported by the service had restrictions in place, and a further three had been requested. The Registered Manager maintained a DoLS log to track individual DoLS authorisations in line with the MCA. Applications had been submitted to the relevant authorities.

Records we examined were complete and up to date and restrictions were deemed to be in people's best interest and the least restrictive. When people were subjected to a DoLS order, this fact was displayed prominently on the spine of their care file, so staff would immediately recognise that there were restrictions in place. Where conditions were applied, such as relating to bed rails or medicine management, we saw that these were adhered to. Case notes indicated contact with the registered person's representative (RPR). An

RPR is a person who must be consulted regarding any restrictions in place, and who can advocate on their behalf. We spoke with one person's RPR who informed us that the service informed them of any changes.

Outstanding ☆

Is the service caring?

Our findings

Many of the people who lived at The Mews exhibited behaviours which could be challenging to service providers, but staff understood that this was a part of their condition and not their personality. The registered manager told us that he was proud of the way staff responded, saying, "It is difficult, we are dealing with residents who bite and scratch, but they keep going in being friendly, and providing care with a smile."

The service was extremely caring and supportive. People who used the service, their relatives and other visitors unanimously told us the staff were extremely caring, supportive, attentive and dedicated in their approach. Without exception they commended the exceptional quality of the care they received. One person who used the service remarked, "I'm pleased I'm here. I used to live alone but was fed up. There are people here to talk to and people take the time to listen. Staff look after me one hundred per cent, even the boss one hundred per cent. It's very caring, one hundred per cent! It's incredible how they meet all our needs". This person went on to summarise, "All the staff are good and kind. I get on with them all." This was echoed by other people who lived at The Mews. We were told by one, "I love it here. All the staff are friendly. You'd have to go a long way to find anything better. It's unbelievable how good it is here," whilst another talked about their relationships with staff, "We can have a laugh with staff and always have a bit of fun. They have time to spend with us, but know when to leave us alone." All the staff we spoke with reflected a truly caring nature, and echoed the views of the people they supported. One nurse said to us, "There is a really good atmosphere. We can have a laugh and share a joke with residents; usually at our expense!"

The atmosphere was friendly, homely and caring. Throughout we overheard numerous friendly exchanges between care staff and people they supported, for example, a disinhibited person was chatting with their care worker and used a lot of swear words. At the end of the conversation the care worker joked, "I'm going to get a swear box for you, you are always swearing. I'll be rich!" The person responded with a smile as they settled back into their chair, and muttered another couple of swear words. Disinhibitions were treated in a person centred way.

During the inspection we used a short observational framework for inspection (SOFI) to observe how staff interacted with the people they supported. Interventions were always person centred, and staff were highly attuned to people's wishes needs and moods, respecting people's personal space and sensing when to intervene and when to leave people in peace. They would discreetly observe and keep a watchful eye on people who appeared settled. When involved in one to one conversations they showed kindness and patience, and listened intently to what people were telling them. It was very apparent they were highly skilled at developing strong relationships with the supported people and people felt that they really mattered. A visiting relative told us, "[My relative] has got poor speech but they understand him, staff are so attentive, and I see them cracking jokes together. It's marvellous".

We observed lunch on one of the units. This was a genuinely social occasion and all the people who used the service appeared to enjoy the occasion. People who required support were helped to eat at their own pace, with good communication and eye contact. Staff were assigned to support specific individuals, and

knew how people wanted their food. A relative told us about the person they were visiting, "[My relative] has swallow problems, but tucks in to all sorts of food; they cut it up small so he can enjoy it, and does really well". Throughout the meal we overheard lively conversation between people who used the service with encouragement and support from staff.

All the staff acknowledged that the people who lived at The Mews had physical disabilities or cognitive impairment but did not see this as limiting their life chances and opportunities. They were treated as people with the same needs, wishes and expectations of anyone else. Care was extremely person centred. Throughout our inspection we saw kindly interventions between staff and people who used the service. Staff clearly knew the people they supported well and responded to their needs in a friendly and supportive fashion. For example, one person used a keyboard to communicate; staff took time to listen, waiting until they had finished typing before intervening. The staff did not see communication as an issue and always took time to respond to the person. It was clear the person felt valued. They typed a message for me telling me that they were not ignored and felt listened to.

The rooms of each person who lived at The Mews were all different and reflected the personality of the person, for example we looked in two adjacent rooms, the first had a full shoe rack, neatly stacked clothes and an iron and ironing board. The second was cluttered (the person told us, "It's my den. This is how I like it"). Despite the disorganisation, the room was clean and well maintained. The person showing us around commented, "It is how they like to live. These are their rooms and as long as it is safe its fine".

The atmosphere on each of the units reflected the respective needs and wishes of the people who used the service. For example, the Pennineview Unit was gentle, relaxed and unhurried. Staff were unobtrusive and gave people time and space when they required it, but were on hand to intervene when necessary. Some people chose to spend time in their rooms, and staff would discreetly check regularly, spend time talking with them, or providing support to meet their needs. A visiting relative told us, "Staff are very helpful. [My relative] has Sky TV but has difficulty with the remote control, so they check he is ok when he is watching his television".

The service had utilised modern technology to reduce people's dependency on staff and afford greater privacy, for example, Wi-Fi had been installed to allow people to privately access the internet and correspond with others through email and other social media; some people had their own phone line installed. This meant that people could use their own rooms for private conversations or to conduct research and enquiries without fear of being overheard, and many of the people who used the service had access to satellite television, so they could choose what programmes to watch, either alone or with friends they had made at The Mews.

People felt that they mattered and that their views and wishes were taken into consideration. One person who used the service told us, "I have lots of freedom here and can choose what I want to do. I enjoy it here." The staff understood that people had a right to live the life they chose, and ensured they were not to be confined by their disabilities. One care assistant commented, "We fit around the needs of the residents, some stay up all night or until four in the morning, but that's their lifestyle. We are here for them not the other way around". We found evidence to show that where people wanted to stay up late they were not restricted by the working patterns of the care staff, and the service looked to accommodate their wishes, for example when we spoke to the head cook, they told us that they would continue to serve breakfast "As people are ready and when they get up, it can be in the afternoon sometimes".

Care plans showed that sex and sexuality were considered and where necessary people's needs for privacy were acknowledged. Nor were staff afraid to challenge outmoded views around culture and diversity. For

example we read supervision notes which showed how a care assistant had overheard two people making homophobic remarks. We asked the care assistant about this incident and they explained how they had challenged them in a kind and sensitive way, offering the person the opportunity to view things differently and see how their comments could cause offence.

People who used the service believed that they had a say in how the service was run and that they were listened to, especially when plans and changes could affect their own care and support needs. For example, prior to our inspection a care assistant had been seconded from one unit to another. The secondment was coming to an end, but one person who was being supported by this person approached the registered manager requesting that they remain on their unit. The registered manager told the person that they would seriously consider the request, speak with all parties involved and seek an amicable solution. The person told us that they were happy that their request was being looked into.

People, their belongings and their visitors were treated with dignity and respect. Visitors told us that they could come at any time and always received a warm welcome. One visitor told us that they were always accommodated, for example at Christmas time when the whole family came to visit, they were given access to a larger room. They told us, "It wasn't 'off limits', but we had privacy and could let our hair down".

We saw information about advocacy services was available on noticeboards in each of the units so people were aware of how to seek independent advice. A discussion with the registered manager showed the service was aware of how to access advocates for people who had nobody to act on their behalf. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways such as; writing letters for them, acting on their behalf at meetings and/or accessing information for them.

Outstanding ☆

Is the service responsive?

Our findings

Without exception, all the staff we spoke with, were told about, and observed during our inspection understood that the people they supported had similar desires and aspirations to their own and worked with them to help them achieve their goals. Nobody who lived at The Mews was defined by their disability, but encouraged to live as full a life as they wished. Each person who used the service had a key worker, who would meet with them on a regular basis and discuss their needs. The keyworker completed a 'monthly diary', documenting any activities, issues raised in the past month or change in character. This was used to help review the support received and plan any future care.

People told us they received support which was fully in tune with their needs and preferences and that the support provided was based on them as a person. During our inspection a person who used the service called us over and said, "This place can't be beaten. It's fabulous, they put the residents first. If you want a doctor or a dentist they'll get you one. Whatever you need, they are on to it. They are always thinking what's best for us". A visiting relative told us, "This is the right place for [my relative]. There is a good mix of people, and the staff work hard to ensure needs are met and they encourage independence".

Care profiles were well written, person centred and gave a good summary of needs and wishes, including how people liked their care to be provided and what they were able to do for themselves. They were written in a way which put the person at the centre of their care, for example, 'Involve [P] in decisions about what clothes to wear'. They encouraged self-sufficiency, independence and supported personal risk taking, enabling people to maintain full control over their own lives and how they wanted to live.

A care needs summary gave a good breakdown of interventions for the day. In one care file we looked at it was stated that routine was very important to the person, and provided a daily routine. For example, for the morning it stated, 'medicine, breakfast and shower in that order. If this is changed [P] can become frustrated and upset.' This routine was always followed, and showed how the staff supporting people who used the service knew them well; understood the triggers which would have a negative impact on their mood, and would work proactively to ensure their safety and well-being.

Care files included generic and specific risk assessments as needed, for example, risk assessments for one person gave instruction to minimise harm if a person refused to take their medicines, and actions should the person not wish to use their wheelchair. Profiles included details of the person and an up to date photograph, for which consent had been obtained showing that the person had been consulted about their care needs and agreed to the way these needs were met.

We looked at seven care files. Each provided a really good background to the person; a pictorial life story covered schooling; employment; residence; family and hobbies, and a written history fleshed out more detail, such as important milestones in the person's life. This meant that anyone unfamiliar with the person would be able to gain a clear understanding of the person, their needs, their lifestyle choices and their value base.

Care plans were very easy to follow and well referenced. Each included sections on personal care and physical well-being; maintaining a safe environment; nutrition and hydration; sight, hearing and speech; oral health; foot care; mobility and dexterity; toileting; mental state and cognition; social interests and hobbies; personal safety; carer and family involvement, and communication. If the person had no needs in any of these specific areas this was noted, for example, in the section on mental state and cognition a mental capacity assessment form would only be completed if the person had questionable capacity. Where needs had been identified, the care plans gave staff instruction on how to support the person, for example one care plan described a person's mobility and dexterity: 'Independently mobile but tendency to bruise due to choreic movements. Monitor movement and let be as independent as can be. Wheelchair for distance, with safety belts. Give room to manoeuvre freely'. Ensure correct footwear is worn'. This showed that care plans reflected need and the staff who helped to draw up the plans alongside the individuals understood how needs could vary over time, space and environment and gave consideration to each of these factors whilst maintaining the dignity and independence of each person.

The Unit manager on each unit would check care records monthly, and make any changes required, for example, under oral health we saw a review which stated, 'due to cognitive problems [P] needs prompting to maintain oral health'. Care plans were always reviewed with the person or their representative every six months or when there was a change in circumstances or need, and all care plans were fully reviewed and re-written every year, providing opportunity for the person to reflect on and reassess their needs. Goals were set with each individual, aspirations were nurtured and people were encouraged to consider novel ways of meeting need. Nothing was considered 'off limits'; physical disability was not seen as a barrier to participation, and people had fulfilled their ambitions by participating in, for example, wheelchair canoeing and rock climbing.

People told us that they were kept stimulated at The Mews. One person said, "There is a lot going on. There's loads of activities, and lots of stimulation. We all get on with each other, so we can sit and chat and the staff will spend time with us". People's hobbies and interests were recognised and taken into account. When we toured the building we found some of the people's own rooms bedecked in the colours of their favourite football team, and we heard that football was a topic of much cajoling, ribbing and lively conversation throughout or inspection. We found when we toured that people used their rooms to entertain and spend time with each other. They told us, "We are happy here, and I have made some great friends," and, "We are really settled here. We all get on. I've made lots of friends".

The service focussed on providing person centred care and support, and we saw exceptional results particularly when it came to maintaining, nurturing and encouraging social interests. The service employed three dedicated activity coordinators known as the 'hobby team' who worked innovatively to overcome the obstacles of physical disability, and to challenge preconceptions of what people could or couldn't do. They worked with people individually or in groups, and kept a diary of activities undertaken each day, with whom, and measured the success or otherwise of the activity. This ensured that nobody's social needs were overlooked. We spoke with one activity co-ordinator who informed us that trips to the cinema to see certain films could be extremely popular, and would sometimes see the same film six or seven times, accompanying a person on each trip.

At the start of the year each person who used the service was helped to compile a 'wish list' of activities they would like to undertake. The hobby team would attempt to meet all the requests, some as one-off events, whilst others had become regular occurrences. Some people enjoyed the theatre, and visits had been arranged, and visits to local art galleries and museums had stimulated interest and led to visits further afield to more specialist museums such as the Imperial War Museum and other art galleries. One person enjoyed legal debate, and was escorted to Crown Court each week where they could listen to real cases being tried.

We were told visits to the Christmas markets were always popular as were 'pampering sessions' at the local college.

Additional activities were arranged each day within the service, and included visiting entertainers, animal therapy, or exercise classes. There was a volunteer aroma therapist and a reiki therapist who visited every week. Coffee mornings and other events were arranged to raise money for MacMillan Nurses, Red nose day and Children in Need.

Birthdays were celebrated. One person said to us, "They make a fuss on our birthdays: balloons and things, and help our relatives get in to visit." People were asked if and how they would like to celebrate their birthdays; on the second day of our inspection we saw one person had chosen to celebrate their birthday by going on a shopping expedition with a member of staff. A visiting relative told us that for their relative's birthday they had brought in a country and western singer at the person's request.

The Mews had a positive and transparent approach to complaints. Any complaints received were managed in line with the provider's complaints policy. An easy-to-read document was available and used to good effect. We looked at the complaints file and saw that all complaints had been logged and gave clear explanations as to how the matter would be resolved. Complaints raised included reference to the menu, which led to an overhaul of the food provision, greater consultation with people who used the service about tastes and preferences, and a shift in focus to less 'traditional' meals being provided. People told us they were encouraged to raise any concerns with the registered manager who kept an open door policy and was visible on the floor. He told us that this allowed him to identify any problems, deal with any concerns and seek a speedy resolution. He recognised that some people can be reticent when it comes to raising concerns, and consequently introduced a 'suggestion box, encouraging people to write any suggestions, ideas, or grievances anonymously. He saw complaints and concerns as an opportunity to drive improvement. When we asked people about complaints they told us that they were aware of how to complain but, as one person told us, "There's nothing to complain about here. It's good to be here." A compliment read, "The staff at The Mews have given me my [relative] back. Without their care and support I wouldn't have her in my life. I can't thank them enough for all they have done for my [relative]."

People were fully involved in discussions about their care at the end of their life. When care plans were reviewed with the person they were supported to make decisions about dying. The registered manager told us that they ask all people who use the service, but many of the younger ones told staff that they weren't yet ready to think about their death. Two of the care files we looked at did include advanced decisions, that is, a record written by the person recording any medical treatments they did not want to be given in the future. These files also showed consideration of how they would like to be supported at the end of their life.

Six members of staff had recently completed 'Six Steps to Success' training. This is a programme designed to include people and their families at the end of life and offering a person centred approach to death and dying. When a person who used the service was dying the hobby team continued to provide support, for instance, spending time with them, sitting and reading to them or just holding their hand. People with MND had access to 'breathing space' kits to provide patient led palliative care for people with MND. All were aware and could choose when they want to start using this kit.

Good

Is the service well-led?

Our findings

People we spoke with told us they considered The Mews to be extremely well managed. A visiting health professional said, "Given the complexity of all the [people who use the service] it runs remarkably well," and a relative commented, "There is a real sense of community. There is always something going on. Staff respect that [group] activities aren't suited for everyone, and not everyone wants to join in, but those that don't aren't neglected, all their needs are taken care of, and they encourage people to be independent. The care they provide to people is based on what they need and want so nobody is ignored". A member of staff said, "It's a great home, well managed with great care. It says a lot that staff don't leave".

A registered manager was in place at the time of our inspection. 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. The registered manager was present during each day of the inspection. He had been managing the Mews for five years having been senior nurse and deputy manager during the previous twelve years, and was keen to maintain a progressive, open and dynamic culture. People we spoke with held him in high regard. A member of staff said, "[He] is a great boss. He's flexible, and will listen, but can be firm when he needs to be, for example, I'll get told off if I come in late, and he checks up on us to make sure we are on the right track. He's responsive not only to the residents but to our needs as well."

The registered Manager knew and understood the needs of all the people living and working at The Mews. One person who used the service told us, "He's the best man going. Better than most, and he makes it nice here for all of us." Throughout our inspection we saw he interacted well with all the people who used the service and supported the staff. When we arrived on the second day of our inspection for instance we found him helping a person to put their socks on. "See," the person joked, "He does have his uses." The registered manager responded in kind and told us that the person had a good sense of humour, and, "I want them all to feel they can just be themselves" Evidence throughout the inspection showed he had succeeded; such was the care and support and encouragement to people to remain as independent as they could it took some time and was easy to forget that the people who lived at The Mews had disabilities; this appeared secondary to their needs to live as regular a life as they could.

There was a good team ethic and staff understood their roles to support people. The registered manager told us, "There is a friendly, homely and caring attitude about the team. We all have the same goal; to make things right for people and let them be happy with what they want" We observed a real sense of community, staff were always willing to help; people who used the service appeared well cared for, well supported and supported one another.

The registered manager was well supported by unit managers and senior staff, and by the owners of the service. The Mews had changed ownership since our last inspection and the new providers were keen to deliver high quality provision of care in a comfortable environment, and to invest in the service. For example, they had replaced the roof and arranged for a new boiler to be fitted. At our last inspection we found the

service was in breach of regulation 15 of the Health and Social Care Act (2008) Regulations 2014, as some equipment and parts of the premises were not maintained or suitable for their required purpose. The new owners had completed all refurbishment work and replaced all worn and dangerous equipment. They were also keen to listen to the needs of people who used the service and had attended a recent resident meeting where they were informed of an issue regarding the weather shield to one of the entrances to the building. This had been causing a minor obstruction as people in wheelchairs entered or left the unit. The owners had arranged for this to be fixed, and during our inspection we saw that this was being addressed.

Governance was well embedded into The Mews' processes and a sound framework to monitor performance and activity had been established across all aspects of the service to ensure continuous improvement. The registered manager completed spot checks, including night visits. He told us he completed a daily 'walkaround' of the home, "Because spending time just watching and listening is vital". He explained that by observing practice he could recognise where things were going well or badly and plan improvements to the service as necessary.

The unit which mainly housed people with Huntington's disease was known as the Huntington's Disease Unit. Shortly after our inspection we queried if this was an appropriate name. The registered manager agreed to consider alternative names for this unit in line with the other two units and to consult with people who used the service. We were later informed that the name of the unit had changed and is now known as Pennineview. This shows that the service is willing to listen to criticism and seek improvement. References in this report reflect the new name.

People who used the service were encouraged to comment on how the service could be improved. Residents' meetings were held every three months, and all were invited and assisted to attend. One person with Huntington's disease told us, "I've been down to meetings, they give us all a say". The agenda was set by the people who used the service, and people told us that actions were followed up by the staff and managers, for example, changes to the menu, and the action around the lip to the entrance to one of the units. We also saw suggestion boxes on each of the units for any person to leave comments or thoughts on how the service could be improved. The registered manager told us that these had recently been introduced as a way of allowing people to make suggestions anonymously, but most of the people who had made comment had signed their name. There was a survey conducted every month focussing on a specific aspect of service provision. Recent topics included, medical care, meeting care needs, hairdressing, food choice, dignity in care. Views of people who used the service, staff visitors and other stakeholders were solicited and analysed to seek positive and person focussed changes to service delivery.

We saw a comprehensive list of audits undertaken on all aspects of service provision with attention to all details, such as a recent pillow audit to ensure pillows and other bedding was still fit for use, or needed replacement. We looked at monthly audits of pressure care, infection control, and individual care plans and a recent Night Visit Audit. Where issues were identified in all the audits we looked at notes demonstrated action taken to improve the delivery of care and support in a way which reflected the needs of the people who lived at The Mews. For example in the care plan audit we saw instruction to all staff to be mindful of use of abbreviations 'to ensure that care plans are person- centred and can be understood by the person to whom they refer'.

CCTV had recently been installed to monitor and improve the safety and security of all the people who used the service; this after full consultation and agreement both with staff and people who used the service. We were told that the week before our inspection a person tripped in a corridor. This was seen on camera and assistance was provided immediately.

The maintenance officer completed weekly jobs as routine including checks of the nurse call and alarm panel, water temperatures and flush. Where external recommendations had been made these were acted on. For example we saw that the service had only received a four star rating from the food standards agency. We saw the report which showed the kitchen on one of the units did not have a separate sink for hand washing. We were told this was acted upon immediately and we saw a new sink had indeed been installed. This showed the service responded to issues raised by external bodies and was keen to meet the highest standards in all aspects of service delivery.

The registered manager was an active member of care partnerships in Rochdale borough and a member of Greater Manchester Huntington's disease support group. He told us that he was keen to learn from similar agencies and to listen to how other providers had overcome problems and to implement new ideas. He provided training in conjunction with the local Health Authority for student GP's and junior doctors every two to three months. This not only provided valuable experience for the doctors but also helped him and the staff to remain ahead of current practice and research into support of people living with Huntington's disease. He subscribed to nursing and social care journals, to maintain best practice.

The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. We saw any communication with relatives was recorded in care files.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.