Leonard Cheshire Disability

# Dorset Learning Disability Service - 2 Thornhill Close

## Inspection report

2 Thornhill Close
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 5 April 2018 and was announced. The inspection continued on 6 April 2018. The second day was also announced.

2 Thornhill Close is a small residential care home without nursing that is registered to provide support for up to three people aged 18-65 with complex medical, physical and learning needs. It is located in a bungalow with an enclosed rear garden. At the time of our inspection the home was providing support to three people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

The care service at 2 Thornhill Close has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy

There was enough staff to keep people safe and meet people's individual needs. There was a safeguarding policy and procedures in place to protect people from abuse and harm. Staff understood their responsibilities to safeguard people and knew how to raise concerns both internally or externally if required. Staff had a good understanding of people's individual risks and how to manage them positively without being unduly restrictive. There were processes in place to ensure safe recruitment of staff to reduce the risks to people living at the home. Checks were also made of volunteers that worked with the people when doing community activities.

People were supported by staff with the skills, experience and knowledge to meet their individual needs. Staff had an induction into the service. Staff competency was monitored on an ongoing basis through competency checks, appraisals and supervision. The service had a matrix for tracking when staff had last received supervision and when the next one was scheduled. Three staff had supervision frequencies that fell outside the provider's quarterly target. Two of these staff only worked at weekends. When this was raised with the registered manager invites were immediately sent to the respective staff. Staff received mandatory training alongside specific training that enabled them to meet people's complex needs for example epilepsy, Pica (an eating disorder where people will try to ingest items that are inappropriate and have no nutritional value) and autism. Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people there. This provides protection for people who do not have capacity to make decisions for themselves.

Staff interacted with people with kindness, compassion and humour. There was a relaxed and homely atmosphere with staff observed consistently giving their time and responding to people in a patient and timely way. People were supported to maintain relationships with relatives and friends and actively participate in a wide range of community activities. Until recently the service had its own minibus but due to a provider decision to make more efficient use of the fleet of vehicles at its disposal the service were now sharing a minibus with another of the provider's services. This impacted on the ability for people to do community activities spontaneously or individually if it involved the need for a vehicle. Due to the experience of the staff they were able to demonstrate a good understanding of the people living there including their backgrounds, needs, abilities, preferences and wishes. People's support needs were identified, assessed and documented in detailed and personalised care plans.

People's care needs were assessed, monitored and regularly reviewed with their involvement (as their abilities allowed), people important to them and health professionals. The provider had established good working relationships with health professionals and relatives who were contacted and involved in a timely way so that they could contribute to a shared understanding of people's support needs. Relatives felt listened to and involved in their family member's lives. Visiting professionals said the staff were pro-active and said they felt people were well supported. People's desire for independence and meaningful activity was met through a varied range of activities tailored to their abilities and tastes. This gave them the opportunity to lead full and active lives.

People received support in a way that acknowledged and promoted equality and diversity. It recognised their needs as individuals and as part of a small community of people living in the same home. The provider had a complaints policy and relatives knew what to do should they need to complain. They had confidence that if they had a complaint or concern the management at the service would listen to them and help resolve it to their satisfaction.

The registered manager had the skills, knowledge, and approachability to manage the service well and to identify where it could be improved. The manager was able to draw on experience gained as senior support worker. There were systems and processes in place to effectively monitor and evaluate the service provided. The manager was supportive, visible and open to ideas and suggestions from staff.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff had a good understanding of safeguarding and what to do should they suspect or witness abuse or harm.

Risks people face were assessed and regularly reviewed.

There was a robust recruitment and selection process.

There was enough staff to meet people's needs and respond flexibly.

Medicines were managed safely.

### Is the service effective?

Good

The service was effective and had improved to Good.

Staff had a good understanding about mental capacity. People had mental capacity assessments which were reviewed. Best interest decision meetings were held with involvement from relevant persons including family members, health professionals, management and staff familiar to them.

DoLS applications had been made for each person at the home. Management were aware of when authorisations were due to expire. Where an authorisation was outstanding this has been chased by management.

People received support where needed to eat and drink sufficiently in line with advice from health professionals.

People were supported to access health services to help maintain their health and well-being.

### Is the service caring?

Good

The service was caring.

People were supported by staff who were attentive, patient and compassionate in their approach.

People were relaxed in the company of staff.

Staff respected people's privacy and dignity.

People were supported to maintain contact with family and friends.

People were supported by staff who had a good understanding of their needs including their emotional needs, preferred method of communication, likes and dislikes.

People were supported to make decisions by staff who understood the importance of offering meaningful choice.

Relatives felt informed and said staff took action in a timely way when people's needs changed.

## Is the service responsive?

Good

The service was responsive.

Care plans were person-centred, detailed and regularly reviewed.

Activities were person-centred and varied. People participated in these both individually and together.

There is a system to record and monitor complaints and compliments.

The service seeks input from relatives and health professionals to contribute towards a shared understanding of people's needs.

Staff had experience of involving relevant people when considering end of life care.

## Is the service well-led?

Good

The service was well-led.

Staff feel happy at work and well supported by management.

The management were visible and promoted an open culture.

Communication between staff and management was effective.

Management carried out audits and competency checks which helped ensure that quality performance, risks and regulatory requirements were understood and managed.

# Dorset Learning Disability Service - 2 Thornhill Close

**Detailed findings**

## Background to this inspection

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

This inspection took place on 5 April and 6 April 2018 and was carried out by one inspector. The inspection was announced. We gave the service 24 hours' notice because it is small and we needed to be sure that the manager would be in.

In planning the inspection we used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Following the inspection we contacted a physiotherapist and a consultant psychiatrist for feedback.

People using the service could not speak with us. We spoke with two relatives and observed how staff supported people to help us understand their experience. We spoke with the registered manager, the service manager, and three care staff.

We looked at all three peoples' assessment and support plans. We also looked at records relating to the management of the home including staff rotas, medicine administration records, meeting minutes and the recruitment information for three staff.

We pathway tracked all three people living at the service. Pathway tracking is where we review records and do observations to see if people are supported in line with their assessed needs.

Good

# Is the service safe?

## Our findings

People continued to receive a safe service. Staff confidently explained their safeguarding responsibilities and knew what signs of abuse or harm to look out for. They were able to tell us what they would do if they suspected abuse or needed to whistleblow. They directed us to a noticeboard giving information on this. Team meetings included safeguarding as a standing agenda item.

People's risks in relation to eating and drinking, seizures and accessing the community were assessed and plans in place to manage these. This helped reduce the risk of injury to the people and staff. Peoples needs were assessed before they moved in to the home and then on an ongoing basis when living at the home. One staff member explained that if people's risks increased they would "escalate to the registered manager, advise colleagues, record in the daily record chart and speak to relevant health professionals."

Equipment was routinely serviced. The home had employed a person who covered health and safety and maintenance. This person had conducted monthly health and safety tours of the home and recorded findings in an actions log so these could be tracked and the outcomes recorded. The service was also supported by a full time maintenance person who covered eight other services managed by the provider Leonard Cheshire Disability.

People had Personal Emergency Evacuation Plans (PEEPS) in place which guided staff on the most appropriate way to support people to get out of the home safely in the event of an emergency such as a fire or flooding. These were reviewed quarterly. Fire systems (including door closures, heat/smoke detectors and alarms) were regularly tested with a log kept of who participated in drills and how long it took people to evacuate safely. The home had passed a recent annual assessment from the local fire service.

The service had enough staff to keep the people safe and had no vacancies. Staff told us there were always enough of them to meet people's needs, keep them safe and interact with them in meaningful ways that were not rushed. One staff member said, "I think it's fantastic here. You can spend quality time with people." Relatives told us that they felt their family members were safe and "well cared for." The provider annually reviewed people's support needs in order to determine the staffing hours required to. Staffing rotas showed that there was sufficient staff to meet people's needs and to respond flexibly when their needs changed. The registered manager said that they very rarely use agency staff as they strive to have consistency and staff familiar to the people living there. The service has four regular bank staff that they can call on when regular staff are unable to cover. The service manager provides supervision for the bank staff.

The provider had robust recruitment practices in place. Checks had taken place to ensure staff were suitable to support vulnerable people. Pre-employment and criminal records checks had been undertaken of staff at the service. Records included photo identification, application forms detailing work history and qualifications, interview records, references, induction checklists and probationary period completion letters.

People's medicines were managed safely. Staff had received the necessary training to have confidence in

carrying out support in this area of people's lives. Staff had formal observations of their competency with medicines. People's medicines were stored in locked cabinets and included the dates that they were opened. Medicine records clearly showed what medicines people required and the reason it was prescribed. Medicine records were legible and complete. These and the stocks of medicines were checked for errors by staff coming on shift. A staff member demonstrated how they supported one of the people with their medicines. This was done in a methodical and knowledgeable way. The staff member was focused and person centred in the way they engaged with the person. Staff were able to describe what to do if they made an error or the person continually refused their prescribed medicines. When people were supported with community activities staff signed their medicines in and out of the home to ensure their whereabouts were known.

People had protocols in place for when they required 'as and when needed' medicines such as pain relief. A local pharmacy had supplied out of date medicines for one person. This was quickly recognised by staff who contacted the pharmacy on behalf of the person to ensure that replacement medicines were supplied promptly. There was evidence that people had their medicines reviewed for example staff were in consultation with a person's GP as they had noticed a change in the person's day to day presentation following a change in their prescribed medicines.

The home was visibly clean and was free from odours. The service had a weekly cleaning schedule which was up to date and audited. The home environment was in a good condition and well maintained. The bathroom/shower room, toilet and kitchen were visibly clean, uncluttered, and had supplies of hand gel and personal protective equipment such as gloves and wipes. Soiled and clean laundry was kept separate to reduce the risk of contamination or infection. For the same reason the service used colour coded mops and chopping boards. The home had an infection control policy and all staff had received training in infection prevention and control.

The service had a new system to record accidents and incidents. This enabled the registered manager and staff to track issues and know how and when they had been resolved. The system could also be used to identify incidents with similarities and the immediate and underlying cause of accidents or incidents which helped to reduce the chance of them happening again. Trends were analysed by the provider's health and safety lead. Staff meetings included discussion about new safety alerts or incidents which ensured all staff were aware of them and the learning was shared.

Good

# Is the service effective?

## Our findings

People received an effective service from staff. People's needs and choices were assessed and frequently reviewed. This was informed by their pre-assessment and needs specific to the environment in which they lived. One person's plan noted that they liked to access the garden independently in nice weather. We observed this being supported during the inspection. Staff were observed offering people choice throughout the inspection. This included the food they wished to eat, who they wanted to support them, what they wanted to wear and activities they might like to do. People's care plans mirrored this person-centred approach. One person's plan said, 'sometimes prefers breakfast in bed' and 'likes to relax in the bath and take it at own pace.'

Staff received a comprehensive induction which included training in decision making and capacity, dignity and respect and supporting people with medicine. Staff told us that they felt supported and received the necessary training to meet people's needs. Staff told us, and records confirmed, that they also received training relevant to the people living at the home. Staff were notified when they were required to undertake refresher training.

Training was delivered by a variety of methods including face to face sessions, e-learning, completion of workbooks and competency checks. The registered manager used the provider's learning management system to have an overview of what courses staff have started, completed, and the competencies that they had achieved. This was used when putting together the staff rota. Competency checks covered areas such as medicines and moving and handling. The majority of staff had attained a qualification in health and social care. Supervisions were held quarterly and demonstrated two way communication and time for reflection. One staff member said that supervision always included a discussion about areas of their practice or learning that they would like to development. Records confirmed this. Another staff member said that these sessions were not rushed with the registered manager giving them "as long as [they] need."

Each person required support with eating and drinking. People were supported to make choices about food and drink in a way that did not overload them. People were shown packaging and bottles as visual prompts by staff aware of the person's preferred means of communication, for example tapping or pointing at the object, to indicate what they preferred. A staff member showed us the monthly menu which detailed a variety of foods to support a balanced diet and what people enjoyed eating. Where a person had risks identified with eating and drinking these were reduced by staff supporting the person to have a soft diet in line with a plan created in partnership with the local speech and language therapy team. People were given support at their preferred pace and in a relaxed way. Where a person was identified as having an irritable bowel they were supported to have a low fibre diet. Peoples' food and drink intake was closely monitored. Records showed that people were weighed monthly to identify weight loss or gain. This was then used inform decisions about the need for specialist advice for example from their GP or dietician.

People were supported to maintain their health by timely access to relevant health professionals. People's care plans included a record of previous and upcoming health appointments. These included appointments for eye and dental examinations, blood tests, and breast screening. Staff showed awareness of people's

upcoming appointments and their needs in relation to these. We observed a shift handover where the staff communicated well with each other in order that appointments were supported and not missed where these were determined to be in the person's best interests. Where a person had been on a particular medicine for a long period of time to help manage a condition discussions had occurred with the consultant to determine if blood tests would be in the person's best interests to monitor the condition of a vital organ. Similar consultations had occurred when a person had been due for cervical screening and another person had required removal of a number of the teeth. This showed that people's overall health and well-being was considered and supported with timely input sought from relevant health professionals. The potential benefits and impacts of health interventions were always considered.

The registered manager was in the process of updating each person's hospital passport. These included information on people's communication needs, family and GP contact details, support needs, and signs of anxiety and pain.

The service is provided from a bungalow situated in a cul-de-sac on a residential estate. It has level access inside and outside in the enclosed rear garden. There is a summer house that people use in the better weather and there are plans to refurbish a patio area and introduce a sensory garden. After the open plan kitchen was refurbished last year the door to it was not replaced. This resulted in the kitchen being assessed by the provider as a high risk area given peoples' needs. To reduce this risk, whilst respecting people's need to observe and feel involved with activity in the kitchen, the provider had a half door installed. This is only used when hot food or liquids are being prepared.

All staff had received training to understand their responsibilities under the MCA and DoLS and were able to confidently tell us how they sought consent and worked in people's best interests. Staff understood the principles of the Mental Capacity Act 2005 and how it applied to the people there. They were able to tell us when and who they would involve if a person lacked capacity. 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.
Each person had a mental capacity assessment in place which had been reviewed. At the previous inspection these assessments had required review. The assessments had determined that each person lacked the mental capacity to make complex decisions on particular aspects of their lives including medicines, continence management and clothing appropriate to the weather or activities. Because of this, best interest decision meetings had been held with involvement from relatives, staff familiar to the person and health care professionals. At the previous inspection these had also needed reviewing. At this inspection records showed that this had been done.

The service had applied for Deprivation of Liberty Safeguards (DoLS) for all three people living at the home. Two of these had been authorised by the respective local authorities who had supported the people to move to the service. The registered manager was chasing authorisation for one of the DoLS applications. 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).

Good

# Is the service caring?

## Our findings

People were cared for by kind, caring and compassionate staff and the rating continues to be good. One relative said "all the staff are very kind and helpful…care there is as good as it gets. They know [name]." We observed one person with a big smile after being supported by a staff member to have a shower. One person's care plan noted that they found it easier to take their medicines with a spoonful of food and were more accepting of support with their medication after having a cup of tea. Their plan also advised that if they became agitated during personal care that staff should 'give 10 minutes to calm ensuring it was safe to do so.' Another person's plan stated that liked to 'link arms with staff when out to feel safe.' We observed a staff member providing timely comfort and reassurance to a person after they had experienced a seizure. This approach was consistent among the staff team. A relative had emailed the service to express 'much appreciation to you all for the love and care you give [name].'

Due to people's communication needs we were unable to obtain their views but we observed each person smiling and reacting positively whenever they were supported by staff. Staff spoke with them in a friendly and compassionate way and it was clear that they had a good understanding of the people they were supporting. Interactions were natural and warm and there was a relaxed and happy atmosphere. Staff listened and responded to people in a patient and respectful way that demonstrated to them they what they were trying to express was important. People were given the time to process and respond to questions from staff. This was in line with guidance within people's care plans for example one of which said '[name] likes to have freedom to express [themselves].' We observed them dancing and making noises to music they had chosen to put on in their room.

Staff upheld people's right to privacy and a dignified life. For example, people were given extra support with their continence needs and choice of clothing when accessing the community in order to maintain their comfort and dignity. Staff told us that one person was inclined to remove clothing when over excited in the community. Staff reduced the risk of this impacting on the person's dignity by supporting them to have a selection of clothing which did not include zips. Care plans reminded staff when people wanted private time. This was achieved by a level of least restrictive monitoring that balanced each person's need to have time to themselves with the identified risks of each person being left alone. One care plan noted that the person liked to have some time under their duvet in their room if they were feeling emotional. Staff were aware that another person indicated that they wanted some time alone by "nodding their head, sitting on their hands and closing their eyes."

Although none of the people were known to be in an intimate relationship the registered manager said that if that changed the service would support them by seeking health professional guidance and requesting a mental capacity assessment to determine what support they may require to maintain the relationship and stay safe.

People living at the home were non-verbal. Decisions about their care and support were based on a robust understanding of their body language alongside discussion with their relatives and health professionals. People's care plans were clear in detailing the extent to which people needed support with particular tasks

and what they could achieve themselves. For example, one person's notes around meal time support stated, 'Collects own meal from the kitchen. Will spread butter on toast with hand on hand encouragement.' Another person's plan detailed that staff were required to support with applying cream after a bath but noted that '[name] may help a little if encouraged to do so.' This meant that people were actively supported in ways that helped them maintain and develop their skills.

The home understood its obligations under the Data Protection Act. Staff had received training in information governance. Files were only taken out in order to complete a particular task and were then returned to secure storage after this was done. Access to computer records was password protected. People's care plans were stored out of sight in a drawer but this was not lockable. We saw that this has been identified in the Service Manager's audit and action is proposed to ensure that these records are stored in a place that can be locked.

Good

# Is the service responsive?

## Our findings

People received responsive care and the rating continues to be good. Each person had a care plan that was personalised to meet their individual needs. These plans were developed with input from relatives, staff and health professionals and had been reviewed and revised as people's needs changed. Care plans clearly documented how staff could communicate effectively with each person. For example one person's plan advised staff that they should 'use key words and keep any verbal communication clear and simple.' One person's plan documented key words that they understood and new ones that they had started to use. The records were written respectfully in the third person and worded in a way that celebrated people's positive attributes for example one said '[name] has a great laugh and a beautiful smile.'

Due to their experience in the service the staff understood the people well. Each person had two keyworkers. This level of consistency enabled staff to meet peoples' needs by interpreting and responding to their facial expressions and other cues from their body language. One person was supported in their purchase of clothing to ensure that items were not too tight or restrictive which would have caused them to feel uncomfortable or distressed due to a particular condition they live with. Another person who required dentistry work was supported to attend on a few occasions rather than one to make the experience less traumatic for them. Staff also supported this person to secure a supply of smaller continence pads than they had previously had as this reduced the risk of them getting a heat rash.

People were encouraged to be individuals and were supported to do a variety of activities that were tailored to what they liked doing. For example on the first day of the inspection a person was supported to have lunch out before going on to see a show at a seaside theatre. Another person had been supported to purchase tickets for a show that they had first enjoyed watching on TV. One person's care plan advised 'walks are very important to [name].' This demonstrated that people's individuality and preferences were acknowledged and formed the basis for decisions about their lives. Every person's bedroom had been personalised and contained items and mementoes that they enjoyed interacting with including sensory lighting, family photos, magazines and soft toys.

People were supported to stay in contact with relatives and maintain and develop new friends. One person was supported to visit a friend in another service that they enjoyed going for walks and having tea with. Some people had email contact from relatives which was then shared with them by staff. One person had a card on display from a relative wishing them well for Easter.

The home had a complaints policy and leaflets which had been supplied to relatives and health professionals. The service had not received any complaints since the last inspection. The registered manager knew what to do to respond to a complaint in line with the provider's policy. The registered manager showed us a database which they would use to manage complaints. Relatives told us that they felt involved and consulted about their family member's care needs and reviews that took place. One relative said, "They always inform me of changes. I am always invited to reviews." Another relative said, "I think they are really good. From what I know I would give them 10 out of 10. They are brilliant. I have a lot of respect for them. I appreciate the care they take of [name]."

Relatives and staff told us they knew how to complain and felt that they would be listened to and action taken to resolve any issues.  Relatives told us that they had no concerns with the service that their family member's received.

Although none of the people had end of life care needs at the time of our inspection staff were able to tell us what they would do to support a person and their family in such circumstances. Staff supported people at the service to observe their faith.

Due to people's complex needs easy read versions of written information were not appropriate. Instead staff used objects of reference to introduce choice or to let people know what would happen next. To prevent people being overwhelmed when making decisions, and to make it meaningful, staff had learned to limit the range of choices offered whilst acknowledging people's preferences and motivation to try new things.

People were supported with a variety of activities according to their taste. This included reflexology, music therapy, attending church services, carriage riding, and trips to the theatre. Care plans identified that some people liked celebrating certain events and seasonal festivities and also clearly detailed when certain events or times of the year made some people feel more anxious. Staff knew and respected that this could be the trigger for more heightened behaviours and offered alternatives and extra support on and around these times.

Good

# Is the service well-led?

## Our findings

The service was well-led. The registered manager worked closely with the service manager. They were both passionate and committed in supporting the people to receive quality care and support that recognised their individuality. The manager was visible and seen as approachable. Staff said the service manager's door was always open and that they were "very approachable." The registered manager said they felt they had brought "a calming influence to [the service]." The staff said the registered manager had contributed to the service being "a good place to work." One person's supervision record noted that they felt there was 'a good team ethic and supportive colleagues and [registered manager]…staff have knowledge and are very helpful.' A staff member told us, 'It is absolutely fantastic here. We are well supported. The registered manager has brought a relaxed atmosphere." Other staff members said, "I feel very happy and content working here….everyone supports each other and works well" and "It's a very good environment to work in…it's the best place I've worked."

The registered manager and service manager had a good understanding of CQC requirements in particular to notify us all particular incidents including allegations of abuse, DoLS authorisations and events that can stop the service such as flooding. Staff were aware of the role of CQC, of external agencies, such as local advocacy services, and the provider's governance arrangements.

Staff told us that management acknowledged when they had been working well and this served to motivate them. A staff member told us that the registered manager would spend time helping them to reflect on their strengths and weaknesses in order to improve the service that people received. Records confirmed this with one documenting the progress staff had made since the last meeting and their particular strengths. It stated, 'excellent relationships and attitude towards [people]. A staff member said, "[the registered manager] thanks you for what you do." We saw evidence of this in people's supervision records one of which stated, '[Name] is a valued and trusted member of the care team at Thornhill.' The staff member also told us that the registered manager was "the best one we've had" and "supports us in everything he can. [The registered manager] goes the extra mile…[the registered manager's] priority is the people that live here and us as well." Another staff member said that on returning from a period of ill health the registered manager told them that they were a valued member of the team and it was good to have them back.

There were effective lines of communication in place including staff handovers and a communication book which gave staff the ability to share important information. All entries were numbered to support tracking and staff had signed to say they had read the messages. Minutes of well attended bi-monthly staff meetings included discussion around people's health needs and current risks, upcoming training and health and safety. Staff signed to confirm they had read and understood the minutes of these meetings. The minutes indicated that open participation and discussion was encouraged and this was confirmed by the staff that we spoke with. A staff member told us that on a day to day basis "[the registered manager always finds time to answer questions…and genuinely cares."

One relative said they were "always made to feel more than welcome" whenever they visited the home. They felt communication was good and timely, rating the home "10 out of 10" whilst adding that the staff

"always inform me if there are problems. I would give the home 10 plus out of 10." Another relative, who lived a considerable distance from the service, told us, "the staff are so nice on the phone and informative. They take action when needed and always involve me. They make me aware when reviews are happening." The service had established good links with their neighbours. This had led to the neighbours fundraising for the home. This money and access to a legacy fund was going to be used to improve the garden facilities ready for the summer. The registered manager told us that neighbours also visited the service at times people were celebrating their birthdays or seasonal events.

The provider had a quality assurance process that included regular service manager visits to the home with an assessment of the service under CQC's five key questions. The provider produced quality monitoring inspection reports following these visits with actions clearly identified for follow up by the registered manager. Supervisions between the service manager and registered manager included a review of completed and outstanding actions. The service manager also conducted quarterly service audits. These included review of people and staff feedback, sampling of people's care plans and staff files, the home environment and training undertaken. The service uses the provider's service improvement database to get an overview of monthly audits (for example medicines) which has been completed, partially completed, or is outstanding. This tool has been available to the service for approximately 14 months. The database also identified when actions related to a particular person are required. At a team meeting staff had used CQC's key questions to inform a discussion around best practice. Staff had talked about what they could do as a service to keep people safe. A staff member told us that team meetings were "open" and that people were "supported to disagree."

One professional told us that 'the staff team were very receptive and in agreement with recommendations' when advising them of what equipment would help one of the people feel more comfortable when sitting. The staff were working closely with a local hospital consultant to monitor this person's health and well-being after a recent reduction in medication they have for a particular condition. Staff understood what this approach was trying to achieve and were fully conversant with what they needed to do in partnership with the health professionals to secure the best outcome for the person. There were lots of examples of staff seeking support and following guidance offered by a range of health professionals in order to meet people's overall health needs. This included speech and language teams, GPs, wheelchair services and a specialist footwear consultant at a local hospital.