Iver House Limited

Ivers

Inspection Report

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Overall summary

Ivers is a care home that provides care and support for up to 25 adults with a learning disability. There were 24 people living there at the time of our inspection. People referred to themselves as students and lived in either the main house or one of four bungalows built on the site. Some of the people who lived in the home did not use words to communicate and some had complex support needs.

At the time of our inspection, the home was actively recruiting to fill the position of registered manager. We spoke with the area manager who explained that the previous registered manager left in November 2013 and since then a number of interviews had been held. This process was still underway at the time of our inspection. The interim management arrangements included the provider's area manager being based at the home to support the deputy manager.

We spoke with people who told us they were happy living in the home. We observed that people who did not use words to communicate were mostly smiling, and their body language indicated that they were relaxed. People interacted with each other and staff throughout our inspection. We heard chatter, laughter and saw a focus on activities.

People were involved in a wide range of activities both within the local community and on site. Staffing levels were maintained at a level that ensured these activities happened.

People were involved in most decisions about their care and support. When this was not possible the home followed the principles of the Mental Capacity Act 2005 to ensure that decisions about care involved appropriate specialists and representatives and were made in people's best interests.

People's preferences and interests were recorded and we saw that care was delivered as described in person centred care plans. Person centred care plans describe what is important to the person and the support they need to live their life the way they want. We saw that people were supported by staff that engaged with them and worked at a pace that suited them. We saw staff communicated with people; some staff were more effective in their communication because they were skilled in using people's chosen communication systems such as signing but this was not standard across all staff.

The home was clean and well maintained and personal areas were decorated and furnished to reflect individual taste and lifestyles.

There was a clear management structure in the home and staff, representatives and people felt comfortable talking to the managers about concerns and ideas for improvements. The managers had recently undertaken audits and developed action plans to ensure that staff had the support and training they needed and that people's care plans and risk assessments were up to date. We saw that the actions identified had happened.

At our last inspection we found that care plans and risk assessments were not always reviewed and updated appropriately to ensure they reflected changes in people's needs. We saw that these were now being reviewed and updated in line with people's changing needs.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There were enough staff to make sure that people were cared for safely. People told us that staff were available to them when they needed help. We observed staff supporting people when they needed support. Families told us that there were enough staff.

Care plans and risk assessments held enough detail to ensure that people received appropriate and safe care.

Staff handled medicines safely and we saw that people received the medicines they were prescribed.

Staff were aware of signs and indications of abuse and knew how to report concerns. Local health and social care professionals told us that they were confident in the home's reporting of safeguarding issues.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Are services effective?

People, their representatives and specialists were involved in assessments and care planning. We saw that people received care and support in ways described in their care plans.

The home worked with other professionals and health care agencies. Local health and social care professionals told us that the home liaised well over people's care plans, prepared well for meetings and kept records as requested such as sleep and food charts. People saw health professionals in a timely manner for both regular appointments such as optician check-ups and flu jabs and when they became ill.

People had access to advocacy services. We saw that some people attended events run by a self-advocacy organisation and when appropriate referrals had been made an advocacy service. The advocacy service was able to provide advocates to support people to have their voice heard within a range of decisions and processes including day to decisions and those that require an independent mental capacity advocate under the Mental Capacity Act 2005.

People's communication was not supported effectively. We spoke with staff about this and they explained that they had not received training in the communication methods that people used.

Summary of findings

Care plans were effective in ensuring support for identified risks. For example, we saw that risk assessments and support plans were in place about risks of malnutrition and dehydration.

Information was not always passed between different locations on the site. For example, between the office and the house. This meant that there was a risk that important information was not recorded about people's well-being.

Are services caring?

People and family members spoke positively about the care people received. One family member told us: "This is a fantastic place with wonderful, calm, attentive, skilled, caring and professional staff."

Staff were knowledgeable, respectful and caring when they spoke about people and were consistent in the way they described people's abilities and the areas they needed help with.

We observed that staff were engaged with the person they were communicating with. Time was given to allow people time to process information, and people were not hurried to make choices or to move through tasks. Where direction was needed from staff to defuse difficult situations this was done subtly in a way that protected people's dignity.

People were encouraged to make their needs known. Keyworkers spent time with people to ensure they were involved in planning their care.

Local health and social care professionals told us that it was a "nurturing" environment where people received "flexible support".

Are services responsive to people's needs?

People were given the time and support they needed to make a range of decisions such as planned activities, food, use of free time. Their care plans reflected individual preferences and the outcomes they wanted to achieve.

Staff worked in a responsive way. For example, we saw staff giving people enough time to process information and be ready to undertake tasks. Staff were also calm and confident when people became agitated.

Changes in care and social needs were recorded. A system was in place to ensure care plans were updated monthly or if a person's needs changed. People were engaged in activities both in the grounds and in the community. We saw that most people were

Summary of findings

involved in activities in the community more than two times a week and often much more. The care plans reflected an understanding of the risks of social isolation and we saw that efforts were made to encourage community based activity for everyone.

People's relationships with their families were supported and innovative ways were sought to help people stay in touch. For example, people used iPads so that they could see their families when they spoke.

There had been one complaint recorded in the last year. This had been responded to quickly and the response addressed the concerns raised clearly. We saw that informal concerns raised by people to staff were also dealt with in a timely manner.

Are services well-led?

At the time of our inspection, the home was actively recruiting to fill the position of registered manager. We spoke with the area manager who explained that the previous registered manager left in November 2013 and since then a number of interviews had been held. This process was still underway at the time of our inspection. The interim management arrangements included the provider's area manager being based at the home to support the deputy manager.

Observations and feedback from staff, people, professionals and families showed us the service was open and welcoming.

Incidents and accidents were reported on by staff. We saw that these were reviewed by the managers and actions were put in place to avoid repeat reoccurrence. The home had made notifications to CQC about incidents that were notifiable under the Health and Social Care Act 2008.

Potential risks were managed across the organisation as a whole. We saw that a system was in place to ensure that changes and risks were identified for action in a weekly report to the managers.

The managers were introducing new systems and procedures to the home and had recently undertaken an audit of staff support and training and care records. We saw that they had found gaps in both but had put robust plans in place to ensure quality standards improved.

Summary of findings

What people who use the service and those that matter to them say

We spoke with nine people who lived in the home and observed three people who did not use words to communicate. We spent time with people over the course of two mealtimes, during activities and free time.

After the inspection site visit, we spoke with a social worker who provided feedback from the local multi-disciplinary team and received feedback from three family members.

People spoke positively about the staff that supported them. One person said: “It is good” another told us about all the activities they did with obvious pride. Families also described the care their relative received positively. One family member told us that their relative was: “extremely well cared for.”

We also heard from families that staff were responsive to people’s needs. For example: “The staff have noticed when [name of relative] wasn't enjoying an activity, namely animal care and taken note of where [name of relative] gravitated to and made the necessary changes to [their] timetable.”

We heard from another family member that: “They know [name of relative] very well, what works and what doesn't and have always listened to our views.”

Local health and social care professionals described the home as providing “nurturing, person centred care”.

Ivers

Detailed findings

Background to this inspection

We visited the home on 1 April 2014 and 2 April 2014. The inspection team consisted of a lead inspector and an Expert by Experience. The Expert by Experience was a family carer with experience of services for people with learning disabilities. 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 regulations associated with the Health and social care Act 2008 and to pilot a new inspection process under Wave 1. Wave 1 is the first testing phase of the new inspection process that we are introducing for adult social care services.

At the last inspection in January 2014 we had identified problems in relation to care plans. The provider sent us an action plan on 20 February 2014. The action plan detailed how they would resolve these problems by 15 March 2014. Prior to the inspection we also reviewed information sent to us by the provider since our last inspection.

We spent time observing care in the main house and three of the bungalows. We looked around the main house including the activities room, dining room, lounge and one bedroom. We looked around the kitchens and one bedroom in each of the three bungalows.

Some of the people had communication difficulties so we spent time with them and observed the care and support staff provided. We spoke with nine people who lived in the main house and three of the bungalows and eleven staff who worked in all areas. We observed the care of three people, who did not use words to communicate, over the course of two mealtimes, during activities and during free time.

We looked at four people's care records and records that related to the management of the home including policies and procedures, care records medicines records, staffing rotas, staff supervision records, complaints, and meeting minutes.

After the inspection site visit, we spoke with a social worker who provided feedback from health and social care professionals working in the local multi-agency team and received feedback from three family members.

Are services safe?

Our findings

We observed people interacting with each other and staff. They did not display any signs of anxiety. They were relaxed and comfortable with each other and we heard laughter at times throughout our inspection. We saw that when people were concerned about something they found staff members or went to the office to speak about it with the managers. Families told us that they felt their relative was safe.

Staffing rotas showed that staffing levels were maintained at a level that allowed for agreed safe supervision levels and activities. We spoke with four staff and the managers about staffing levels. They all told us that there were enough staff to make sure people were safe and could engage in activities. We saw that where people had dedicated staff support the staff member wore a wristband that identified this to other staff and the person. We observed that this tool was used to ensure that appropriate and safe support was maintained in a respectful and unobtrusive manner.

The grounds provided a safe environment within which people moved freely. The front gate was closed but not locked. This meant that people could leave when they wished but the physical barrier prevented people from walking on to the road unintentionally.

We looked at the arrangements for the management of medicines. Administration records were accurate and medicines had been stored and disposed of safely. We saw that most medicines were dated when they were opened. However, we saw that some medicines were open but not dated. Once opened some medicines have a shelf life. There was a risk that medicines would be used after the date that they should be disposed of. A senior member of staff acknowledged this and ensured the medicines were still effective and safe to use. We looked at three people's medicines administration records and saw that they reflected the medicines they received. Staff who administered medicines were trained to do so and staff who worked with people who might need emergency medicines for seizures had specialised training to ensure they could do this safely. We looked at the use of medicines as part of behaviour management and saw that no one was prescribed medicines to help them manage their behaviour when they were agitated. We discussed this with a senior member of staff. They explained that they worked with health professionals to help people manage their anxieties and behaviour without medicines whenever possible.

We spoke with four staff about how they would report concerns about abuse. All staff were able to describe who they would speak to within the organisation. Staff also knew what to do if their concerns were not addressed in that they would report them to other agencies. Not all staff knew who these agencies were, but they were able to explain where the information and contact details were kept. We saw that safeguarding concerns had been raised appropriately with the local safeguarding authority and reported to the Commission. Health and social care professionals told us they were confident that safeguarding alerts were always made appropriately.

We looked at four people's care plans and risk assessments and saw they were written in enough detail to protect people from harm. Risk assessments covered risks related to activities such as working with animals, using garden machinery, risks associated with people's behaviour and mental health. We saw that some risk assessments had been updated since our last inspection and a system had been implemented that enabled staff to update the senior staff of any changes needed. We saw that risk assessments were used to support people to take informed decisions about risks. This gave people the opportunity to choose to develop their skills and become more independent. For example, we saw that one person had started to go shopping alone. Their risk assessment for this activity identified ways to both mitigate problems that might arise and increase their confidence.

People were involved in planning how they would be kept safe. Some of the people who lived in the main house and bungalows could become physically and verbally aggressive when they were agitated or anxious. We looked at four care plans and saw that there were risk assessments and person centred support plans for staff designed to keep the person and those around them safe. We saw that people were involved in designing these support plans. For example, we saw in one person's care plan that they had identified all the things that made them agitated and how they wanted staff to support them with these.

The home learned from incidents and accidents and put plans in place to reduce the risk of them reoccurring. Any incidents and accidents were recorded and viewed by the

Are services safe?

managers. We looked at the incidents recorded for four people and saw that they included information that helped staff and managers evaluate what had happened. We saw that any learning or actions needed were also recorded.

People's human rights were properly recognised, respected and promoted with regard to where they lived. While no applications for Deprivation of Liberty Safeguards had been submitted, proper policies and procedures were in place. Staff had recently had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We spoke with three staff about these and they were able to talk about how consent worked in practice.

Some of the people living at the home did not have capacity to make decisions about their own care. We saw that the home worked in accordance with the principles of the Mental Capacity Act 2005 to ensure decisions were made in people's best interests. For example, one person who would not take medicines had a best interest decision recorded involving a relative, staff at the home and the person's GP that led to them receiving this medicine covertly. Where people could not consent to their care a best interest decision was usually recorded for their care plan. We saw one care plan that did not have this best interest decision recorded.

Are services effective?

(for example, treatment is effective)

Our findings

People, their families and specialists were involved in assessments and care planning. We read four people's care plans and saw that people who lived at the home had been involved in the assessments of their needs. We heard from a family member that: "They know [name of relative] very well, what works and what doesn't and have always listened to our views." Another family member commented that they had been involved in planning for their relative's move and this planning was "outstanding." We saw that care plans were written with specialist input when necessary.

People received care and support as described by their care plans. Staff told us that the care plans reflected the care and support people needed. We asked four staff about people's care needs and they were able to describe current support needs consistently and confidently. The care plans contained details such as people's likes and preferences and the goals that people were working towards. For example, one care plan said: "I will be able to tell people if I am feeling ill without becoming anxious or cross." We saw from daily records that support reflected this goal. People's choices and preferences were respected in their care plans. For example, we saw what people needed to stay well and happy was recorded and that activities were planned to achieve this.

People had access to advocacy services. We saw that some people attended events run by a self-advocacy organisation and when appropriate referrals had been made an advocacy service. A senior member of staff supported groups where people spoke up about things that mattered to them.

The home worked in partnership with other professionals. Health and social care professionals told us that staff at the home liaised well over people's care plans, prepared well for meetings and kept effective paperwork such as sleep and food charts to assist professional involvement. However they said staff at the home did not always contact them in a timely manner when people's support needs changed. Both health and social care professionals working in the local community team described a recent situation when they had not been informed quickly about significant changes in someone's behaviour. They did not feel that this had a detrimental impact on the person, but highlighted that it led to a delay in staff receiving additional professional support and expertise. It is important that services communicate with other professionals in a timely manner to ensure effective responses when people's needs change.

People were supported to maintain good health. People saw health professionals for both regular appointments such as optician check-ups and flu jabs and when they became ill. We spoke with staff about how people communicated pain. We saw that this information was recorded in care plans and where possible included people's preferences about accessing medical professionals.

People had specialised health assessments and care plans. For example, staff commented on the effectiveness of support plans for people with epilepsy. Where people found it difficult to have health assessments and treatments there were plans in place to reduce the risks that this created. For example, people had risk assessments about not seeing the dentist that described how these risks were reduced. Support plans were also in place to help people overcome their anxieties when seeing health professionals. For example, one person had visits at home where no assessment or treatment was undertaken to help them become more familiar with the health professional. Records reflected this support work when it was done by, or under the guidance, of other professionals such as a psychologist or community psychiatric nurse. However, when the support plan was designed by staff this was not always recorded. There was a risk that if key staff were away that this information could be lost and well considered plans not followed.

People's communication was not supported effectively. We spoke with staff about this and they explained that whilst people used different tools such as PECS and Makaton the staff were not all trained in how to use these systems. PECS and Makaton both support communication. PECS uses pictures to help people communicate and Makaton is a form of sign language. Some staff had received training in their previous employment and were able to use these skills, but other staff did not have these skills. This meant that people could not always communicate effectively with the staff supporting them. We spoke senior staff about this, they told us they had trialled a communication training programme and planned to introduce this.

People were protected from the risks associated with nutrition and hydration. We saw that a risk assessment and

Are services effective?

(for example, treatment is effective)

care plan was in place for a person who was at risk of malnutrition and dehydration. Where necessary people's weight was monitored. We observed that the care plan was followed and staff were able to describe the risks for this person. People were given choices around their food and drinks. We spoke with two people who told us they liked the food.

There were effective support plans in place around people's behaviour. Some of the people living in the home could become anxious or agitated in certain situations. We saw that the policy about behaviour management placed people's rights at the centre of how they were supported. We saw evidence of this in a care plan that had been recently updated. It identified how the person liked to be supported when they were upset. We saw four detailed behaviour support plans which emphasised positive early interventions. This meant that, whenever possible, staff were able to support people in ways that avoided an escalation of anxiety and agitation.

Important information was not passed between different parts of the service quickly enough. We saw information was not passed between the office and the house in a timely manner and as a result daily records did not fully reflect a person's wellbeing. This meant there was a risk that their care might not be delivered appropriately.

Are services caring?

Our findings

We spoke with nine people about the ways they experienced their care and support. They all spoke positively about the staff that supported them. One person said: “It is good” and another told us about all the activities they did with obvious pride. Families also described the care their relative received positively. One family member told us that their relative was: “extremely well cared for.” Another family member told us: “This is a fantastic place with wonderful, calm, attentive, skilled, caring and professional staff.” We observed that interactions were positive between staff and people. We gathered feedback from local health and social care professionals. They told us that it was a: “nurturing and person centred environment where people received flexible support.”

People were supported in ways that promoted their independence. They worked alongside staff and shared tasks. For example, we saw people asked which ‘chore’ they would like to undertake as part of a shared meal. When people had chosen their tasks staff helped them as necessary.

People were respected by the staff. We observed that staff were fully engaged with the person they were communicating with. Time was given to allow people time to process information. We saw that people were not hurried to make choices or to move through tasks. Where direction was needed from staff to diffuse potentially difficult situations this was done subtly in a way that protected people’s dignity. For example, we observed a member of staff communicate clearly to another member of staff what they needed to do when a person became agitated. They did this without drawing anyone else’s attention to the situation and in a manner that spoke positively about the person concerned. The staff modelled respectful communication when they spoke with the people living in the home and with other staff. Staff also adapted their communication style to ensure they engaged with people. For example, we saw a member of staff use word games to remove stress from an interaction.

Staff spoke about people with care and respect. We spoke with four staff about people’s individual support needs and their preferences. They were knowledgeable, respectful and caring in their responses. They were consistent in the way they described people’s abilities and the areas they needed help with. Care plans were written respectfully and celebrated people’s successes. For example, one care plan stated: “I am now very good at going to tell staff if I am upset or need help.”

People were encouraged to make their needs known. We saw that this happened informally throughout our inspection. People always received a response from staff to initiated communication and requests. We also saw that people had keyworker time scheduled weekly to discuss and explore their needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People were given the time and support they needed to make a range of decisions such as planned activities, food and use of free time. We saw people being given the space and time they needed to make decisions and then support was provided at the time it was needed. We also observed that staff focussed their interaction on the people and did not communicate with each other unless it was necessary to do so.

Care plans were based around individual preferences and the outcomes people wanted to achieve. We saw that a new recording system had been introduced and was being used to make sure the care people received was based on their individual preferences and aspirations. Where people did not have the mental capacity to make specific decisions this was recorded and best interest decisions were made in line with the principles of the Mental Capacity Act 2005. A best interest decision involves people who knows the person who does not have capacity well. They consider things that matter to the person when they make a decision on their behalf. We saw that keyworkers had time to spend with people to ensure they were involved in planning their care. We heard from a family member that staff were responsive when their relative indicated, without words, that they were not enjoying an activity. They told us: "The staff have noticed when [name of relative] wasn't enjoying an activity, namely animal care and taken note of where [name of relative] gravitated to and made the necessary changes to [their] timetable."

At our last inspection we found that there had been a breach of legal requirements because care plans and risk assessments were not always reviewed and updated appropriately to ensure they reflected changes in people's needs. We saw that these were now being reviewed and updated in line with people's changing needs. Some of the people who lived in the home had needs that were known to change regularly. Risk assessments detailed the signs that staff should look out for and what different support would be needed when these signs were reported. For example, we saw that risk assessments around a person's nutritional needs now reflected both the person's current care needs and indicated at what point a different approach would be needed.

Staff were confident in responding to people when they became agitated. We observed staff responding calmly when a person became upset and agitated. A family member told us they were always informed when a situation had arisen when their relative was involved with an incident with another person. They were confident that action was taken to manage these situations in a timely manner.

A new system had been implemented following our last inspection to ensure care plans were updated monthly and when needed. We saw that this had happened in two care plans but it was too soon to determine if this system was being used regularly. Any changes to care plans were identified in a weekly report from each bungalow and the main house. We saw that one report described a change that was needed to a person's epilepsy plan and we saw that their care records had been updated to reflect this.

People took part in activities both in the grounds of the home and in the local community. These activities included animal care, bowling, drama and swimming. The home had previously been registered as a residential college and it retained an emphasis on activity and group work. We saw that everyone was involved in activities in the community at least two times a week and often much more unless they did not like to leave the grounds. The care plans reflected an understanding of the risks of social isolation and we saw that efforts were made to encourage community based activity for everyone. A group from the home ran a toddler group in a local town. They talked with pride about this work and were busy stock taking and cleaning the toddler group toys, cushions and other resources during the inspection. We also heard that events such as a fashion show were planned with a local day centre to afford people the opportunity to meet others. One person told us: "I like the animals best" and described some of the animal care tasks they undertook. Activities were available in the evenings as well as the day time. Another person told us they went to computer club after tea and enjoyed using the internet. We were also given a preview of songs from a forthcoming drama production that will be performed in the local community.

Trips were planned based on people's likes. Two people told us about a trip to London to a museum and one person had just been to see a show. A senior member of staff explained how the staffing arrangements were changed to make sure trips happened. A family member told us that staffing was never an issue when it came to arrange trips out.

Are services responsive to people's needs?

(for example, to feedback?)

People's relationships with their families were supported. We spoke to people who explained how they used technology to stay in touch. We saw that they were supported to put photographs of their activities and information onto a secure Facebook page for their families to share. We spoke with staff who told us this was important contact and that online risks were managed. A family member described how the staff supported their relative to use face time on their iPad in place of phone contact which had not been possible.

There had been one complaint received in the last year. It was responded to quickly and the response addressed the concerns raised clearly. We saw that informal concerns raised by people to staff were also dealt with efficiently. For example, one person came in to express concern to staff in the office about a task they needed to do. A solution was found quickly and the person's role in finding the solution was acknowledged. Families told us they felt comfortable raising concerns with staff and managers. We saw that there was an easy read complaint form available, but this contained out of date information and had not been used by anyone living in the home. Although we saw some people were comfortable expressing their concerns there was a risk that people were not being encouraged to complain when appropriate. There was also a risk that people, or their representatives, might not know who they should complain to because the form contained out of date contact details.

Are services well-led?

Our findings

At the time of our inspection, the home was actively recruiting to fill the position of registered manager. We spoke with the area manager who explained that the previous registered manager left in November 2013 and since then a number of interviews had been held. This process was still underway at the time of our inspection. The interim management arrangements included the provider's area manager being based at the home to support the deputy manager.

Observations and feedback from staff, families and people showed us that everyone was encouraged to share their views. Staff told us that they felt comfortable approaching the managers. One staff member said: "I can tell them what I think. They do listen." Another member of staff gave an example of a time they had said a care plan was not appropriate and the managers had listened. People told us they were happy living in the home. They told us they liked their rooms and the staff who helped them. They told us they enjoyed their activities. Three people told us who they talked to when they were upset or unsure, and explained they received help when they needed it. People's opinions were gathered in ways that were meaningful to them. For example, we observed staff that had just run a pottery session gathering immediate feedback.

We saw there was an open door policy in operation and staff and people came to see the managers throughout our inspection. We spoke with senior staff about the way they managed the service. They told us that they aimed to be approachable and to encourage staff and people to share any concerns. They also made sure they spent time in the house and bungalows so that they knew the staff and people and understood what was happening for them. Family members told us they were able to approach staff to discuss concerns and that these were addressed. One relative highlighted that there was never a reluctance to respond to issues raised. They did, however, also comment that sometimes communication regarding outcomes was not forthcoming. It is especially important when supporting people with communication difficulties that families are kept up to date to ensure that they can contribute to support plans.

Staffing levels were maintained at a rate that made activities possible despite vacancies. People told us that staff were there to help them. All the staff we spoke with told us that staffing levels were appropriate. The managers described difficulties recruiting in a rural location but ensured that staffing levels were maintained through use of agency if necessary. We looked at the rota and saw that staffing levels had been maintained over the week of our inspection and the previous week.

Audits were used to improve the organisation. The managers had recently undertaken a review of care plans and staff support. We saw that they had identified actions that were needed. For example, we saw that omissions from care plans had been identified and keyworkers and the senior staff had time allocated to work on the care records. The managers had also identified that some training and supervision sessions were not up to date for all staff and had introduced a new monitoring system. We saw records that showed some staff did not have current training. For example, the provider expected manual handling training to be updated every two years and we saw that 16 staff had not done this. We spoke to the managers about this and they were confident that rotas reflected that there were always staff available that had the skills and knowledge needed to support people safely and appropriately. They had identified the same gaps in training and had developed an action plan to provide the training. Staff had recently undertaken training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We saw that time had been scheduled to assess staff's understanding following this training.

Potential risks were managed across the organisation as a whole. We saw that a system was in place to ensure that potential and emerging risks were identified in a weekly report to the managers. We saw that the managers acted on this information. Incidents and accidents were also reported on by staff. These were reviewed by the managers and actions were put in place to reduce the chance of repeated occurrence. The home had informed us about incidents that were notifiable under the Health and Social Care Act 2008. We saw that actions described in notifications had been taken. Health and social care professionals also told us that when they requested actions be put in place following safeguarding concerns these were always followed.

Staff meetings were used to ensure shared understanding between managers and staff. We saw the minutes of two meetings since January and the agenda for a forthcoming meeting. We saw that meetings had covered training needs

Are services well-led?

and plans and that practice issues were discussed. This meant that staff and managers had a shared understanding of training priorities. Senior staff told us that discussion about practice issues ensured all staff were working with shared values. We also saw that a situation identified during the inspection had been added to the forthcoming agenda.