Bondcare (London) Limited

Beechcare Incorporating the Peter Gidney Neurological Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Beechcare incorporating the Peter Gidney Neurological Centre is a care home providing accommodation with personal care and nursing for up to 66 people. The service provides support to older people with nursing needs, including people living with dementia and adults with a range or neurological conditions, such as acquired brain injuries. The service operates across two units each with its own communal areas, one of which is dedicated to people with neurological conditions. At the time of our inspection there were 61 people using the service.

People's experience of using this service and what we found
People and their relatives told us they felt safe living in Beechcare incorporating the Peter Gidney Neurological Centre. One relative told us, "[Relative] is definitely safe because I raised a concern about door security, and it is now on a timer." Another relative said, "I feel [relative] is safe, they have completed risk assessments around the care and the quality of care is good."

People received safe care and treatment from staff who knew them well. One person said, "They know me as a person to care for me." One relative said, "They know [relative's] likes and dislikes." Another relative told us, "They know what [relative] likes to do and what they like to watch on television." People and their relatives spoke positively about the staff.

Medicines and infection control were both managed safely, and lessons were learned when things went wrong. There was a range of activities offered, including group and individual activities and people could choose whether to attend.

People were involved in decisions about their care and they received care which promoted their dignity and encouraged independence. Relatives told us they were involved in their relative's care and were kept up to date with changes, either in the home or with their loved one's condition. The service produced regular newsletters to share information.

Effective quality assurance processes were in place to monitor the service and regular audits were undertaken. Staff had received appropriate training. There was a new manager in post and staff told us they found them approachable and supportive with an open-door policy. People and relatives agreed and told us the new manager was making improvements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 November 2021) and there was a breach of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This inspection was prompted partly by a review of the information we held about this service, and to follow up on actions we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to good based on the findings of this inspection.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well led.

Details are in our well led findings below.

Beechcare Incorporating the Peter Gidney Neurological Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Beechcare incorporating the Peter Gidney Neurological Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Beechcare incorporating the Peter Gidney Neurological Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this

location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 months and had applied to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection including details about incidents the provider must notify us about, such as serious injuries. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff and the person themselves. In this report, we used this communication tool with 2 people to tell us their experience. In addition, we spoke to 5 people without using the tool.

We spoke 8 relatives about their experience of the care provided. We observed multiple interactions between people and staff throughout the day. We spoke with 12 members of staff including the local and regional management teams, nurses, care staff, physiotherapist and support staff. We looked at records relating to people's care and support including risk assessments, care plans and medicine administration records. We looked at 5 staff recruitment files. A variety of records relating to the management of the service were reviewed including health and safety checks, meeting notes, training records and audits.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
At the last inspection the provider had failed to deploy enough staff to support people safely. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● There were enough staff deployed to meet peoples' needs. The service used a dependency tool, updated monthly, which helped the manager calculate the number of staff needed. People, relatives and staff told us they thought there were enough staff. One person said, "I always see staff around, if I need them they come."

● Staff had been recruited safely. Records were maintained to show that checks had been made on employment history, references and the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safe recruitment decisions.
● Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their personal identification number to confirm their registration status.

Systems and processes to safeguard people from the risk of abuse
● Staff were knowledgeable about safeguarding and knew how to report signs of abuse and to whom. Staff were confident that actions would be taken if they were to report something. Staff told us and records confirmed that safeguarding training was up to date.
● Staff had recorded and reported allegations of abuse to the appropriate authorities. Safeguarding records were completed and showed staff cooperated with investigations.
● People and their relatives told us they felt safe living in Beechcare incorporating Peter Gidney Neurological Centre. One person said, "There are staff around, it makes me feel safe." A relative told us, "[Relative] is safe, they keep on top of things. I can't fault them on that front." Another relative said, "[Relative] is safe there and there are always people walking around."

Assessing risk, safety monitoring and management
● Risk assessments were clear, comprehensive and up to date. They contained enough information for staff to provide safe care and manage any risks, such as falls, skin damage or choking. Some people had risks associated with complex health needs, these assessments were highly detailed and included, for example, information about signs to look for that could indicate life-threatening complications.
● Where people required monitoring charts such as weight, fluids or repositioning, these were in place and had been completed correctly. Where people required special pressure relieving mattresses, the required

settings were documented and checked regularly. People received safe care and treatment by staff who knew them well.
● The provider had a robust system in place for regularly reviewing the care plans and risk assessments and these were up to date. Any changes in a persons' needs were shared with staff during handover meetings, which were documented.
● Environmental risks were managed including fire safety, water, windows, gas, electrics and maintenance of equipment. Fire drills were held regularly, and all maintenance checks were up to date. The service had a refurbishment plan in place.

Using medicines safely
● Medicines were managed safely in line with national guidance. Medicines were stored securely in clean, temperature-controlled conditions. People told us they got their medicines on time. Medicine administration records were completed accurately.
● Medicines were administered by nurses who had been trained and assessed as competent by the clinical lead. Training and competency records were comprehensive and up to date.
● Medicines were audited regularly and monitored by the clinical lead. Medicine errors were documented, investigated and lessons learned shared during clinical meetings.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
Visitors were welcomed in the service at any time and there were no restrictions on visiting.

Learning lessons when things go wrong
● There was a system in place for recording accidents and incidents and staff knew what to do if someone had an accident. Records had been completed and were up to date. Professional advice was sought if necessary, for example, from the GP or emergency services.
● Accidents and incidents were investigated. Investigation records were thorough and included actions plans and lessons learned. Risk assessments and care plans were updated after incidents to ensure information was shared with all staff. Senior managers had oversight of accidents and incidents and these were discussed at regular clinical meetings.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

- The manager introduced coloured crockery following research results that found a 25% increase in food consumption for people living with dementia. As a result, staff told us people were eating better and some people's weights had increased. For example, one person's weight increased by 1.2 kg in one month.
- Feedback from people and relatives about the food was mixed, some people enjoyed the food, but others found it to be lacking in flavour with poor variety. People described the food as 'basic' and 'okay, but nothing great'. However, one relative acknowledged the food had improved since the new manager had taken over. They told us, "There is still room for improvement but it's getting there." We fed this back to the service so they could monitor the improvements.
- People were supported to eat and drink enough. Food preferences, allergies and intolerances were documented, and kitchen staff were aware of them. However, not all preferences were respected. For example, one relative told us, "The food needs to me more tailored to what people like". A person told us staff regularly served him a vegetable that he consistently said he did not like. They told us, "They know I don't like it, but they always give it to me. I won't eat it or anything that it is mixed with." We fed this back to the manager who said they would address this.
- Menus were on display in the service with more than one option at each mealtime. People chose where to eat their meals. People had regular input from dieticians and speech and language therapists, depending on their needs. Where dieticians had recommended people were weighed regularly, weights were recorded, and weight loss or gain was monitored through clinical meetings.
- People who were at risk of choking had been assessed by speech and language therapists and were protected from risks with modified food and fluids. Staff were aware of these risks. Some people received their food and drink through a tube into their stomach. These were always managed by nurses or care workers who had received additional training to undertake these tasks.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were assessed before they moved into the service to ensure their specific needs could be met. The pre-admission assessment covered all aspects of a person's life, including protected characteristics under the Equality Act 2010. The pre-admission assessment was used as the basis for developing the person's care plan.
- People's needs were assessed using recognised tools, such as, the Malnutrition Universal Screening Tool (MUST) and the Waterlow score to assess skin integrity. Peoples' assessments included culture and spiritual needs.
- People's care plans were comprehensive; they contained enough information for staff to know about

peoples' individual choices and wishes. Care plans were reviewed and updated regularly. People had comprehensive oral health care plans and staff supported people to maintain good oral hygiene. Staff supported people to access dental service where appropriate.
● Care delivery was person focused and responsive to peoples' needs. Staff had a good knowledge of people and their individual preferences and choices. Staff understood risks, for example, choking or falls, and knew what to do to keep people safe.

Staff support: induction, training, skills and experience
● Staff had received training and had the knowledge and skills they needed to safely provide care. Training records were up to date. Staff told us if they wanted specific training, they only had to ask, and the manager would source it for them.
● Additional training had been arranged for staff, to meet people's specific needs, for example, Parkinson's disease, epilepsy or diabetes. The service arranged drop-in training sessions for staff on a variety of topics, largely focused around neurological conditions, every 2 weeks. A learning and development folder had been developed for staff to access containing information on a range of health needs, for example, brain injuries and strokes.
● Most people and their relatives agreed staff were well trained. One person said, "I think they are trained and know what they are doing." A relative said, "I feel the staff are well trained. Every time I have a question about [relative] they know what I'm talking about and guide me in the right direction." Another relative told us, "I believe the staff are well trained and they receive ongoing training."
● Staff told us they received supervision regularly. Staff felt well supported by the nurses and the management team. Nurses had regular clinical supervision and worked within the Nursing and Midwifery Council's Code of Conduct.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some people living in the service had complex healthcare needs. Risk assessments and care plans contained details for staff to enable them to manage risks and provide safe care. There were detailed instructions relating to certain health care tasks, such as the management of people's airways, breathing tubes and feeding tubes.
● Staff had good knowledge of peoples' healthcare needs and knew how to support them to achieve good outcomes. We saw care being provided in accordance with the plans.
● There was input from healthcare professionals such as the physiotherapist, GPs and dieticians. GPs visited the service weekly and there was regular contact with the speech and language therapist. People were supported to see podiatrists, dentists and opticians when required.
● People told us they were supported to access a doctor if needed. Relatives told us doctors were involved in people's care. One relative said, "They communicate with the hospital about blood results to monitor their feeds, and the local GP is also involved." Another relative told us, "The doctor is involved with their care." A third relative told us the service had a folder of information about their relative and staff would explain any results of tests or anything else they did not understand.
● People were supported by the physiotherapy team to access the on-site gymnasium to meet their health or leisure needs and support their rehabilitation. One relative told us the physiotherapist and physiotherapy programme got the person walking again and described this achievement as 'amazing'.

Adapting service, design, decoration to meet people's needs
● The service was arranged on one level with ease of access for people with all abilities. We saw people walking around and using self-propelling wheelchairs safely around the service, including in the communal areas. The provider had developed a new sensory area in the corner of the gymnasium which had proved

beneficial in supporting people with their anxieties.
● People's rooms were personalised with photographs and other things that were important to them. One person told us, "The home is clean, they are making improvements." The provider told us there was a refurbishment plan in place and we saw decorators on site during our inspection.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service complied with the MCA. There were decision specific mental capacity assessments, such as use of bed rails or receiving personal care. Best interest meetings were held between staff, relatives and other professionals and decisions documented.
● The manager had made appropriate DoLS applications to the local authority and there were systems in place to keep these under review.
● Care was provided in the least restrictive way. Consent was documented in peoples' care plans. We saw staff asking people before they undertook any tasks.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care

- People were heavily involved in decisions about their care. For example, one person wanted to have visits home, but the equipment they used would not allow this. The service worked with the person and their family to source alternative equipment which meant the person could enjoy regular visits home. Another person wanted to gain the ability to walk again, having been told this may not be possible. After a programme of intensive physiotherapy, the person was able to walk with some assistance. Their feedback to the service said, "Thank you so much for helping me to achieve what I thought wouldn't be possible. Walking and making me physically stronger. Your support has been first class."
- Peoples' care plans were developed with them and their relatives where appropriate. People were encouraged to share their life experiences so that staff could get to know them better. Peoples' likes and dislikes were documented and included, for example, what time they liked to go to bed or get up, where they liked to eat their meals and what their hobbies and interests were.
- Communication needs were documented so people could be supported in the best way to be involved in decisions about their care. Some people were supported to use electronic devices to enable them to communicate with their families. Care plans contained details of people's families and other people who were important to them, their past jobs and lifestyle. People's personal goals and desired outcomes were documented.

Respecting and promoting people's privacy, dignity and independence

- The service worked with other specialist services to ensure people had as much independence as possible, for example, the wheelchair service and spasticity clinic. The physiotherapist worked with people to develop their wheelchair skills. People were referred to the spasticity clinic to reduce the risk of muscle contractures which could impact negatively on a person's mobility. People and relatives told us people accessed physiotherapy services regularly. One person told us, "They do always encourage me to do things myself."
- The manager implemented decorative and personalised dignity aprons for people to wear during mealtimes. These had become a talking point as each person who wore them had their own unique look.
- People were treated with dignity and respect and their privacy was protected. We saw doors closed whilst people were having their personal care tended to by staff. Staff put signs on doors to prevent people entering during personal care.
- Peoples' confidential information was kept securely, accessed only when required and by those authorised to do so. Electronic records were password protected.

Ensuring people are well treated and supported; respecting equality and diversity

● People told us staff were kind and friendly. One person said, "If I want something they are always there." Another person told us, "They are all really nice to me." We saw staff talking respectfully with people. A relative told us, "The staff are all very caring."

● Most staff and people knew each other well. Some staff were new, and people told us they did not always have the same knowledge as others, but they were learning. Staff knew how to communicate with people effectively. One person said, "They know me, and they include me." A relative said, "They understand their communication."

● Relatives told us staff were friendly and approachable. One relative said, "Staff are all really nice to me." Another relative told us, "The staff are very helpful, and they answer all my questions."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were personalised and reflected people's preferences in all areas. For example, food likes and dislikes, whether a person wants to choose their own clothes, gender preferences of people giving personal care, and spiritual or religious needs.
- One person told us, "I do what I want and go around the home in my chair." A relative said, "They know my [relative] as a person. For personal care she prefers female staff and they make sure that happens." Another relative told us, "They give him a choice about when he gets up and goes to bed."
- Any changes to a person's needs were shared with staff during handover meetings. Relatives told us they were updated if there were changes to their loved one's care. One relative said, "The do call me if they need to."
- There was an enthusiastic activities team and a programme of activities on offer. Some were group activities, and some were individual sessions. We saw people engaged in various activities during the day, such as one to one karaoke, singing, dancing and bingo. One person told us, "I won bingo today. I get involved when I want to." Most relatives were positive about the activities on offer. A relative told us, "[Relative] takes part in what they are interested in and there is something available every day."
- Some people did not want to be involved in activities and their choices were respected. One relative said, "[Relative] chooses not to take part in activities." Another relative confirmed that activities were on offer, but the person's condition did not enable them to take part. Some people and their relatives told us they would like to see more activities outside the service.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- We observed staff communicating effectively with people. When people required spectacles or hearing aids, staff made sure they were working, and people used them properly to support better communication.
- People's communication needs were documented in their care and support plans which helped staff understand how people expressed their needs. Some people had technology in place to support effective communication.

Improving care quality in response to complaints or concerns

● The manager had a proactive approach to complaints and concerns raised about the service. The manager liked to deal with issues as they arose and encouraged people and relatives to approach them with any concerns. Complaints were investigated and outcomes shared with complainants in accordance with the company's time scales.

● Where there had been mistakes, the manager apologised and learnt lessons from the concern. For example, one relative had raised a concern about personal care; the manager ensured the staff concerned apologised to the person and their relative.

● People we spoke to and their relatives knew how to raise concerns and most said they were dealt with appropriately. One relative said, "There have been a lot of staff changes and I feel it is better now." Another relative told us, "I raised a complaint and it was dealt with. I was happy with the outcome."

End of life care and support

● The service was able to provide end of life care and support which enabled people to remain in the service if their needs increased and not have to move to a new service. Hospice teams, GPs and other community services provided support when required and medicines were available to keep people as comfortable as possible.

● Most care plans included clear instructions about end of life care wishes and staff were aware of these. These plans had been written in partnership with the person and their relatives if appropriate. Some people had chosen not to discuss this aspect of their care. Staff had received additional training to support them to provide care at the end of a person's life.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we recommended the provider seek guidance about the standards needed for good care records. At this inspection the provider had made improvements.

- The registered manager recently left the service. There was a new manager in post at the time of our inspection. They had submitted their application to register and CQC were assessing their application.
- There was a clear management structure, nurses and care staff understood their responsibilities to meet regulatory requirements. Staff told us they enjoyed working in Beechcare incorporating the Peter Gidney Neurological Centre.
- The manager met daily with head of departments to ensure that key messages about people were shared in a timely way. Daily handover meetings were held to ensure staff had up to date information about the people they were supporting. Daily care notes were thorough with several entries made each day.
- The provider had a robust quality monitoring process. A range of audits were undertaken regularly, for example, infection control, medicines, care plans and clinical indicators. Audits results and outcomes were reviewed by senior regional managers. Where shortfalls were found during audits, there was a clear action plan in place with timescales and we saw these had been adhered to.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The manager promoted a positive culture within the service where people felt empowered and involved, and there was a commitment to continuous improvement with a service improvement plan, updated regularly. The manager had an open-door policy and encouraged staff, people and relatives to share their views. Staff told us they felt able to report things and were confident appropriate actions would be taken.
- Staff told us the culture was open and honest with good teamwork and they found the manager supportive and approachable. The service was committed to staff learning and development and arranged regular drop-in training sessions on a variety of relevant topics. Staff we spoke to were highly knowledgeable about the people they were supporting.
- People and their relatives knew who the manager was and agreed they were approachable and supportive and 'the door is always open'. People told us they saw the manager around the service regularly. One relative said, "I know the manager. They have improved the home since they became manager. They are more visible and seems to care more about the care people receive." Another relative told us, "I know

who the manager is, I can talk to them or email them."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. The provider understood their responsibilities.

● Services providing health and social care to people are required to inform the CQC of important events that happen in the service. This is so we can check that appropriate action has been taken. The manager had correctly submitted notifications to CQC.

● Relatives told us, and records confirmed that staff were in regular contact with them. One relative said, "The keep me involved." Another relative told us, "I visit every day and am involved in everything. They keep me updated."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some staff had champion roles, for example, in infection control, Mental Capacity Act, dignity, dementia and mobility. This provided staff an opportunity to take more responsibility in their roles.

● Staff were invited to meetings and encouraged to contribute. Staff told us they had regular supervision sessions and nurses had clinical supervisions.

● Some relatives had filled in a survey and told us actions had been taken based on their feedback. At the time of our inspection the manager was in the process of arranging individual meetings with all relatives to talk through every element of their loved one's care and support plan and to listen to any concerns and suggestions for improvement.

● Relatives told us communication had improved recently; they received a newsletter and there was a Facebook page where they could find updates. The manager held group meetings with relatives. One relative told us, "I have been to a meeting and it was a good opportunity to raise any concerns." Another relative said, "I do attend the meetings. They have become more useful recently." However, other relatives were not able to attend the meeting due to other commitments at that time of the day. The manager was aware of this and planned to offer alternative times.

Continuous learning and improving care

● Nurses attended regular clinical meetings where key clinical issues and risks were discussed, such as wound management, weight loss and complex health risks. Action plans were in place to ensure issues were addressed and reviewed, for example, referrals to dieticians or specialist nurses. Senior managers had oversight and had clinical risk meetings with the service.

● The service was committed to continuous improvement and lessons learned from incidents, accidents or complaints were discussed and shared with the team with strategies in place to minimise the risk of recurrence.

Working in partnership with others

● The manager had a good working relationship with local authority safeguarding and commissioning teams. The manager and nurses worked in partnership with local health and social care teams.

● Other professionals were actively involved with the service, for example, doctors, hospital consultants, dieticians, speech and language therapist, and specialist nurses.

● The service engaged regularly with other services, such as the wheelchair service and spasticity clinic to ensure people's opportunities and outcomes were explored and maximised.