Hawkinge House PAU Limited

Hawkinge House Proactive Assessment Unit

Inspection report

1 Hurricane Way
Hawkinge
Folkestone
CT18 7SS

Tel: 01303895072
Website: www.hawkingehouse.co.uk/proactive-assessment-unit/

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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
Hawkinge House Proactive Assessment Unit is a residential care home providing accommodation and nursing and personal care for up to 62 people. The service is arranged across two floors with lift access to upper floors. There were 57 people using the service at the time of our inspection. Hawkinge House Proactive Assessment Unit mainly provides short term nursing and care for people awaiting assessments of ongoing care and support needs from health and social care teams. In the last three-month period 193 people had used the service, 150 of these were new admissions.

People's experience of using this service and what we found
People told us they felt safe and were happy in Hawkinge House Proactive Assessment Unit. One person told us, "I'm living like a Lord." Another person said, "Yes I feel safe. I like to be independent. I have a very pleasant room and I get on well with the staff." People received safe care and treatment from staff who knew them well.

Medicines were managed safely, and lessons were learned when things went wrong. The service had good infection control measures in place. There were enough staff deployed to safely meet peoples' needs. Staff had received appropriate training.

People received care in a respectful manner which promoted their dignity and encouraged independence. Privacy was maintained and people told us staff asked for their consent before supporting with personal care or other tasks.

People enjoyed the food and their dietary needs and preferences were met, for example vegetarian or vegan. People told us they had choices, but if they wanted something different, they only had to ask. One person told us the best thing about the service was the food.

Robust quality assurance processes were in place to monitor the service and regular audits were undertaken in a number of areas for example, infection control and medicines. People and staff told us the registered manager was supportive and approachable with an open door policy and the service was well organised.

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
This service was registered with us on 22 April 2021 and this is the first 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 the service can respond to COVID-19 and other infection outbreaks effectively.

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.

Hawkinge House Proactive Assessment Unit

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
This inspection was carried out by two 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
Hawkinge House Proactive Assessment Unit 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. Hawkinge House Proactive Assessment Unit 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. This included things the provider needs to tell us about, for example, serious injuries or safeguarding concerns. We sought feedback from professionals who work with the service. 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 spoke with 17 people who use the service and 11 relatives about their experience of the care provided. We spoke with 13 members of staff including the registered manager, compliance manager, clinical lead, nurses, care workers and supporting staff. We spoke with five professionals who worked with the service, including an occupational therapist and social worker. We reviewed a range of records including nine peoples' care records and multiple medicine administration records. We looked at four staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, such as audits, meetings, monitoring activity and training were reviewed.

Good

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. Staff were knowledgeable about safeguarding, knew what to report, and to whom. Staff told us and records confirmed training in safeguarding was up to date.
- Records showed staff recorded and reported allegations of abuse to the appropriate safeguarding authorities. The registered manager completed safeguarding records and cooperated with investigations. Actions, outcomes, notification of closure and lesson learned were recorded.
- People felt safe in the service. One person said, "Yes I do feel safe. It's because there are always people in the corridors at night." Another person said, "Yes, I feel safe. It's because the staff are very friendly and helpful." Relatives agreed people were safe. One relative said, "Yes, [relative] is safe. It's a lovely facility. Staff are kind and helpful." Another relative told us their relative was safe because, "They can call staff if they need to. There are always staff around."

Assessing risk, safety monitoring and management

- People had risk assessments completed on arrival to the Proactive Assessment Unit, and an initial care plan was developed. Risk assessments contained enough information for staff to provide safe care and manage any risks, such as falls or choking. The provider used recognised tools for assessing risks such as nutrition and skin damage.
- Where people required monitoring charts such as weight, fluids or repositioning, these were in place and had been completed correctly. Where people required pressure relieving mattresses, the required settings were documented and checked regularly.
- Care plans were reviewed by the clinical lead and any changes shared with nurses and care workers verbally and in writing. Staff read handover notes at the start of each shift to ensure they were up to date with each person's care needs. Compliance was monitored by the registered manager.
- Environmental risks were managed including fire safety, hot water, windows, electrics and maintenance of equipment. Staff had been trained in fire safety and knew how to move people safely in an emergency. A fire risk assessment had been completed recently by an external company.

Staffing and recruitment

- There were enough staff deployed to meet peoples' needs. Staff told us there were enough staff most of the time. People and their relatives thought there were enough staff. One person said, "Yes, I think there are enough staff." A relative said, "Yes, there are a good number of staff."
- Call bells were answered quickly, and call bell response times were checked by senior managers regularly. Everyone we spoke to told us their call bells were answered quickly. One person said, "Staff get to me quickly if I press my call bell."

● Staff had been recruited safely. Records were maintained to show checks had been made on employment history, references and Disclosure and Barring (DBS) records. 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. Nursing staff were required to update their registration annually.

Using medicines safely
● Medicines were managed safely in line with national guidance. Medicines were stored securely in clean, temperature-controlled conditions and disposal was safe. Electronic medicine administration records were completed accurately. People told us they got their medicines on time. One person said, "I'm happy with the way it's done. Tablets are on time, no messing about."
● Medicines were administered by nurses or care workers who had been trained and assessed as competent by the clinical lead. Training and competency records were comprehensive and up to date. Where people had their medicines through a feeding tube, this was only done by trained nurses.
● Medicines were audited regularly and monitored by the clinical lead. Medicine errors were documented, investigated and lessons learned shared during clinical meetings. Staff wrote reflective accounts which were used as a learning tool after any medicine errors.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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
Although visiting wasn't restricted, visitors needed to make appointments. The new guidance on visiting in care homes had not been implemented at Hawkinge House Proactive Assessment Unit. Some relatives told us they would prefer not to have to make an appointment. The provider rectified this immediately after the inspection and a communication was sent to all relatives.

Learning lessons when things go wrong
● There were systems 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. If people had falls they were seen by the occupational therapist to review their care plan.
● Accidents and incidents were investigated. Investigation records were thorough and included action plans and lessons learned. Clinical incidents, such as, medicine errors were investigated by the clinical lead. Actions were taken to prevent recurrence, for example changes had been made to the medicine process as a result of a medicine error.
● Monthly analysis of incidents and key clinical indicators, for example, falls, weight loss or infections were

carried out to identify trends and reduce the risk of recurrence. These reports were shared with staff at meetings. Nurses had access to a clinical folder where the clinical lead stored important information and clinical updates.

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were good, and people's feedback confirmed this.

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

● Peoples' care plans contained enough information for staff to know about peoples' individual choices and wishes. Most care plans had details about the person's life, history and family. Peoples' assessments included cultural and spiritual needs. The service used recognised tools for assessing some risks, such as skin damage and nutrition. Each person was allocated a 'key worker' who worked as a liaison manager. Liaison managers were the first point of contact for relatives and health and social care professionals.

● All staff had a very 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. One person told us, "They know my needs and know me well."

● There was provision in place to support and reassure people who were living with dementia or those being nursed in bed. Staff were seen reassuring people. People told us staff came and chatted to them in their rooms. One relative said, "[Relative] is supported as needed and wanted."

Staff support: induction, training, skills and experience

● Nurses and care staff had received training and had the knowledge and skills they needed to safely provide care. Staff told us they had received training and we saw training was up to date. Staff are reminded when refresher training is due and if they do not complete the training in the required time frame they are automatically suspended from the rostering system, which means they are unable to work until the training has been completed.

● People thought staff were well trained. One person said, "The staff are more than well trained; they know my needs." Another person said, "Yes, they are experts. I'm satisfied." Relatives agreed staff were well trained. One relative said, "Staff are definitely well trained." Another relative said, "From what I've seen they are well trained. They know what they are doing."

● Staff told us they received supervisions regularly. Nurses had clinical supervisions done by the clinical lead. Staff told us they felt supported by the management team.

● Nurses attended clinical meetings and had support from a nurse assessor and a clinical lead. Nurses worked within the Nursing and Midwifery Council's Code of Conduct and revalidated every three years in accordance with regulations.

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

● People were supported to eat and drink safely. People were protected from risks of choking with modified food and fluids following assessments by speech and language therapist and nutritional plans were reviewed regularly. Some people had feeding tubes in place; care plans and risk assessments gave specific instructions for staff on how to maintain these safely and detailed which tasks should only be done by

nurses. Where people needed food or fluid intake to be monitored, this had been recorded correctly.
● There were no menus on display but there was a weekly meal plan available. People were able to choose from a variety of options and if there was nothing on the menu they liked they could choose something else. The menu stated, 'The choice is yours'. There were enough staff to support people who needed assistance to eat and drink, either in the dining room or in their rooms. A range of hot and cold drinks were offered throughout the day. Staff were knowledgeable about peoples' food allergies and intolerances and those who needed modified diets, such as pureed food.
● Most people and their relatives were complimentary about the food and told us they had plenty to eat and always had access to drinks. One person said, "The food is gorgeous here, sometimes I could do with a bit more." Another person said, "The food is very, very good." Peoples' individual dietary needs were catered for. For example, one person said, "I'm vegetarian; the staff have gone out of their way to help." Another person said, "They are trying so hard to help me. They have printed a Vegan menu for me."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The registered manager and staff worked very closely with other health and social care professionals, who either visited the service or had contact with the service daily. Visits are done regularly to assess peoples' ongoing care and support needs. There are regular review meetings between the service and continuing healthcare teams.
● Assessments and care plans included peoples' health care needs and there were details of healthcare professional's visits in individual's records. Information was shared with others, such as hospitals, if people needed to access these services.
● Nurses and care staff had good knowledge of peoples' healthcare needs and knew how to support them to achieve good outcomes. There was input from health care professionals such as GPs and dieticians. We saw care being provided in accordance with the plans.
● People told us they could see a doctor if they wanted to and staff would arrange this for them. One person said, "The doctor is called if I am unwell." Another person said, "If I'm not well, I'm sure they would get the doctor. They've not needed to" A relative said, "Yes, they get a doctor and a [specialist] team in to see [relative] really quickly." GPs visited the service twice weekly.

Adapting service, design, decoration to meet people's needs
● The service was arranged on two levels with a lift to facilitate ease of access for everyone. We saw people walking around the service and using self-propelling wheelchairs, including in the communal areas. There was a designated quiet area at each end of each corridor with chairs and tables where people could sit.
● Directions around the service were clear and communal rooms, toilets and bathrooms had good signage. People we saw walking around the service knew where they were going and how to get back to their room.
● Where people had lived in the service for more than a few weeks, rooms had been personalised to meet their needs. For example, we saw items in one person's room that was important to meet their spiritual needs.

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. Mental capacity assessments had been completed. There were decision specific capacity assessments and best interest meetings were held between staff, relatives and other professionals where necessary. The registered manager had made appropriate DoLS applications to the local authority.
- Care was provided in the least restrictive way. Consent was documented in peoples' care plans. People and relatives told us staff asked consent before providing care and we observed this happening. One person said, "The staff always ask permission before starting care." Another person said, "Yes, they talk things through before they start." A relative said, "Yes, they explain everything to [relative]. They are able to say if they are not happy."

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People told us staff treated them respectfully. One person said, "The staff are kind and respectful. They are all nice; everyone is good." Another person said, "Oh yes, they are friendly and kind. I have a right laugh with some of them."
- Staff knew people very well; they knew their preferences but still offered choice. We consistently saw staff offering choices to people, for example, whether people wanted to come to the dining room for lunch or stay in their rooms. Staff were patient with people and talked with them at their own level.
- Relatives agreed that staff treated their relatives with kindness. One relative said, "Staff are friendly, kind and respectful." Another relative said, "Staff are very friendly. Most of them are putting in the extra effort."

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

- Peoples' daily routines, such as what time they like to get up or go to bed and where they preferred to eat their meals, were documented along with their likes and dislikes. People were involved in assessments about ongoing care needs, for example, decisions to go home with support or choosing a longer-term care service. Communication needs were documented so people could be supported in the best way to be involved in decisions about their care.
- Care plans documented peoples' desired outcomes. One person told us they were determined to walk again. Another person told us they were supported to go to the lounge for meals as they liked to socialise with others at mealtimes. People told us staff knew them well and they were encouraged to express their views. One person said, "They know the things I like to eat, but I can have food from home if I want to."

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect. Care plans gave specific instructions for staff to maintain peoples' dignity and encouraged them to be as independent as possible. People told us their bedroom doors and bathroom doors were closed whilst they were being supported with personal care. One person told us, "Yes, the staff do maintain my privacy and dignity. They knock on the door before coming into my room." A relative told us, "They are ever so good with dignity, they close doors." Another relative said, "Staff seem to be aware of privacy and dignity. They always knock on the door and speak to [relative] respectfully."

- People were encouraged to be as independent as possible. Some people were assessed by physiotherapists and occupational therapists so they could improve their level of independence and return home. People and their relatives told us staff encouraged them to be independent. One person said, "They encourage me to do thing for myself." Relatives told us where people could do things for themselves, they were enabled to do so.

● Peoples' confidential information was kept securely on electronic password protected systems and accessed only when required and by those authorised to do so.

Good

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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 peoples' preferences. For example, food likes and dislikes, gender preferences of people supporting with personal care, and spiritual or religious needs. One person whose faith was important to them had personal items in their room and were able to watch church services on a laptop.
- Some professionals who worked with the service, people and their relatives reported language could be a problem and a barrier to good communications at times. We discussed this with the provider. English lessons were being provided for staff whose first language was not English, but these had been suspended due to the COVID-19 restrictions. However, these had recently been reinstated to support staff with their language skills. The service had organised a multi-cultural week where staff from different cultures shared information, traditional food and games from their cultures. People and their relatives were involved and found it to be a positive experience.
- People were encouraged to socialise in communal areas where they were able, and staff told us they spent time talking with people in their rooms for those who were cared for in bed. Professionals and relatives told us they thought there could be more activities. Due to the short-term nature of the care provided, the service did not have a dedicated activities team. We gave this feedback to the provider and since our inspection a staff member has taken the lead and has started to arrange some activities for people, including a weekly gardening club, quizzes and bingo, and had booked external entertainers.

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.

- Care plans had detailed communication plans for people with instructions for staff about how to communicate effectively with people. For example, for people with hearing difficulties, to face them, talk at their level and speak clearly. When people required spectacles or hearing aids, staff made sure they were working, and people used them properly to support better communication. Staff were softly spoken and showed patience and respect when talking with people.
- The provider told us information could be shared in several formats including large print and audio if required. Information about how the service works is provided to people and their relatives. Signage around

the service was clear.

Improving care quality in response to complaints or concerns

● We reviewed records of complaints. The registered manager had a proactive approach to complaints and concerns raised about the service. Complaints were thoroughly investigated, and outcomes shared with complainants in accordance with the company's time scales. Escalation routes were provided to people if they wanted to take matters further.

● Where there had been mistakes, the registered manager apologised and learnt lessons from the concern. Staff were encouraged to write reflective accounts and lessons learned were shared with staff so that the risk of similar concerns arising could be minimised.

● People we spoke to and their relatives knew how to raise concerns, but most hadn't needed to. A relative told us when they had mentioned a minor issue to the registered manager, action was taken immediately. Overall, people were complimentary of the service they received. One person said, "I get the care I want and need. I have no complaints or concerns." Another person told us, "I have nothing to complain about". Relatives agreed they had no complaints or concerns.

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.

● 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.

● Staff worked with other health care professionals, such as specialist nurses and hospice teams to provide end of life care when required. Medicines were available to keep them as comfortable as possible.

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- The registered manager promoted a positive culture within the service where people felt empowered and involved, and there was a commitment to continuous improvement. The registered manager had an open-door policy and encouraged staff, people and relatives to share their views.
- The provider had worked closely with health and social care partners to drive continual improvement by undertaking specific detailed analyses into a variety of areas, such as accidents and incidents, complaints and training. This had led to continual learning and improvement.
- Staff told us the culture was open and honest with good teamwork. One staff member said of the culture, "It is open and honest and always striving to improve." People and their relatives said the service was well organised. One person said, "I certainly think the home is well organised. Everybody does their job very well." Another person said, "It is a well organised home."
- Peoples' outcomes were good, and people were complimentary about the service. One person said the best thing about the service was, "There is always somebody around." Another person said the best thing was, "The care and attention you get. They look after me very well here." Relatives agreed. One relative said, "It is all good really. They look after [relative] tremendously well. I couldn't ask for more." Another relative said, "This is the most comfortable they have been anywhere. They have come on in leaps and bounds in terms of their mental health."

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.
- Records confirmed the manager had shared outcomes with people and relatives when something had gone wrong.

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

- There was a clear management structure in place, with a deputy manager who was also the clinical lead. Nurses and care staff understood their responsibilities to meet regulatory requirements. Staff told us the management team were supportive and approachable and were confident in reporting any concerns. One

staff member said, "[Manager] is lovely, has really good knowledge and is supportive."
● The registered manager spent time with the staff daily, speaking with them about any key messages or changes. Staff confirmed they read daily handover notes and the registered manager monitored compliance with this. Staff told us changes were communicated to them in a timely manner either verbally or through the care records, so staff had up to date information about the people they were supporting.
● 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. Audit results and outcomes were overseen and reviewed by compliance managers. The service had an infection control lead responsible for infection control audits. A clinical lead took responsibility for medicine audits and monitoring and reviewing care plans regularly and spent time supporting the nurses and care staff.
● The registered manager did random night visits to see staff and monitor care delivered at night. Monthly board reports included an action plan for the registered manager to work through. Progress was monitored at subsequent board meetings.
● 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 registered manager had correctly submitted notifications to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff were invited to meetings and encouraged to contribute. Staff had regular supervision sessions. The results of the most recent staff survey (April 2022) were mainly positive. Where negative comments or suggestions had been received the provider developed a staff feedback action plan which the registered manager had worked through.
● Feedback from professionals who work with the service said communication between the service and people and their relatives was an area requiring improvement. The registered manager had introduced a new role of Liaison Officer, allocated each day to visit everyone to improve communication. A daily walkaround form was in use which had recently been reviewed and extended to encompass more elements.

● People living in the service and their relatives knew who the manager was. One person said, "The manager is very nice, and they know what is going on." A relative told us, "I had a lovely meeting with the manager; they said please tell us if we can do anything better." The registered manager was reviewing methods of obtaining feedback from people who use the service and their relatives whilst they were still in the service.

Continuous learning and improving care
● Nurses attended regular clinical meetings where key clinical issues were discussed, such as medicines and diabetes. Action plans were in place to ensure that issues were addressed and reviewed, for example, referrals to dieticians or specialist diabetes nurses.
● As a new service, the registered manager had fostered a culture of continuous improvement and learning. When incidents or accidents had happened, lessons were learned and shared with the team at meetings or through individual messages.

Working in partnership with others
● The registered manager worked in partnership with local health and social care teams and had a good working relationship with safeguarding and commissioning teams. Professionals visited the service daily and there were weekly multidisciplinary meetings to discuss the progress and next steps of every person using the service.
● The clinical lead and nurses liaised regularly with other health professionals, such as GPs, dieticians, speech and language therapists, specialist nurses and hospice teams.